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IMJ

Illinois Medical Journal

Official Journal of the Illinois State Medical Society

Volume 173, Number 1, January 1988

**Guiding Physicians through the Maze of Options
The ISMS Contract Review Service . . . 19**

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Don't Fence Me In (Or Out)



*Let me ride through the ridge where the West commences
Let me gaze at the moon till I lose my senses
I can't look at hobbles and I can't stand fences
Don't fence me in*

By definition, a contract is a mutual agreement, enforceable by law, that something either will or will not be done. Physicians are increasingly drawn into agreements and contracts which obligate them and limit their lives and practices in exchange for a variety of benefits.

Let's face it—we are neophytes in *LA Law* land. When we sign a contract, most of us do so with a confidence and belief in the wisdom and goodness of human nature and precious little hard-nosed intelligence.

We have seen our profession become more specialized in recent years. Many have limited the field of practice—dropping OB and orthopedic work or otherwise seeking to limit malpractice exposure.

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It's like building a fence. Some fences are good and some are bad. They limit freedom and in return bring order and control. The Illinois State Medical Society is prepared to help you build a good fence, if necessary. In this issue of the *IMJ* we look at this new patient-doctor concern. Our legal special-

know what is important to physicians in practice in Illinois and ISMS will provide this help for a nominal fee.

Elsewhere in this issue, you will find information on what the society's specialists do and how they think about these things. You may want to look into it. ◀

Edward J. Fesco, M.D.

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Brief Summary

CLINICAL PHARMACOLOGY. Pharmacodynamics: Clinical studies of terazosin used in once-a-day (majority) and b.i.d. regimens with total doses usually in the range of 5-20mg/day, in patients with mild or moderate hypertension. Because terazosin, like all alpha₁ antagonists, can cause large falls in blood pressure after the first dose or first few doses, the initial dose was 1mg in virtually all studies, with subsequent titration to a specified fixed dose or titration to a specified blood pressure end point.

Blood pressure responses were measured at the end of the dosing interval (usually 24 hrs.) and effects were shown to persist throughout the interval, with usual supine responses 5-10mmHg systolic and 3-5.8mmHg diastolic greater than placebo. The responses in the standing position tended to be somewhat larger, although this was not true in all studies. The magnitude of blood pressure responses was similar to prazosin and less than hydrochlorothiazide (in a single study). In measurements 24 hrs. after dosing, heart rate was unchanged.

Limited measurements of peak response (2-3 hrs. after dosing) during chronic terazosin administration indicate that it is more than twice the trough (24 hr.) response, suggesting some attenuation of response at 24 hrs., presumably due to a fall in blood terazosin concentrations at the end of the dose interval. This explanation is not established with certainty and is not consistent with the similarity of blood pressure response to once-a-day and b.i.d. dosing. With the absence of an observed dose-response relationship over a range of 5-20mg, i.e., if blood concentrations fall to the point of providing less than full effect at 24 hrs., a shorter dosing interval or larger dose should lead to increased response. Measure blood pressure (BP) at the end of the dose interval; if response is not satisfactory, patients may be tried on a larger dose or b.i.d. regimen. The latter should be considered if side effects, such as dizziness, palpitations, or orthostatic complaints, are seen within a few hours after dosing.

The greater BP effect associated with peak plasma concentrations (first few hours after dosing) appears somewhat more position-dependent (greater in the erect position) than the effect of terazosin at 24 hrs. In the erect position there is a 6-10 bpm increase in heart rate in the first few hours after dosing. During the first 3 hrs. after dosing 12.5% of patients had a systolic pressure fall of 30mmHg or more from supine to standing, or standing systolic pressure below 90mmHg with a fall of at least 20mmHg, compared to 4% of a placebo group.

INDICATIONS AND USAGE: Indicated for the treatment of hypertension.

CONTRAINDICATIONS: None known.

WARNINGS: Syncope and "First-dose" Effect: Terazosin, like other alpha-adrenergic blocking agents, can cause marked hypotension, especially postural hypotension, and syncope in association with the first dose and few doses. A similar effect may occur if therapy is interrupted for more than a few doses. Syncope has been reported with other alpha-adrenergic blocking agents in association with rapid dosage increases or introduction of another antihypertensive drug. Syncope may be due to an excessive postural hypotensive effect, although occasionally the syncope episode has been preceded by severe supraventricular tachycardia with heart rates of 120-160 bpm.

To decrease the likelihood of syncope or excessive hypotension, always initiate treatment with a 1mg dose at bedtime. The 2mg and 5mg tablets are not indicated as initial therapy. Increase dosage slowly, and add additional antihypertensive agents with caution. Caution patients to avoid situations where injury could result if syncope occurs during initiation of therapy.

In early studies, where increasing single doses up to 7.5mg were given at 3 day intervals, tolerance to the first dose phenomenon did not necessarily develop and the "first dose" effect was observed at all doses. Syncope episodes occurred in 3 of 14 subjects given doses of 2.5, 5, and 7.5mg, which are higher than the recommended initial dose. Severe orthostatic hypotension (BP 50/0mmHg) was seen in two others and dizziness, tachycardia, and lightheadedness occurred in most subjects. These adverse effects all occurred within 90 min. of dosing.

In multiple dose clinical trials involving nearly 2000 patients, syncope was reported in about 1% of patients, in no case severe or prolonged, and was not necessarily associated with early doses.

If syncope occurs, place patient in recumbent position and treat supportively. There is evidence that the orthostatic effect of terazosin is greater, even in chronic use, shortly after dosing.

PRECAUTIONS: *General: Orthostatic Hypotension:* While syncope is the most severe orthostatic effect of terazosin, other symptoms of lowered BP, such as dizziness, lightheadedness and palpitations, are more common, occurring in 28% of patients in clinical trials. Patients with occupations in which such events represent potential problems should be treated with particular caution.

Information for Patients: Make aware of possibility of syncope and orthostatic symptoms, especially at initiation of therapy, and of the possibility of syncope or hazardous tasks 12 hrs. after the first dose, after a dosage increase, and after interruption of therapy when treatment is resumed. Caution to avoid situations where injury could result should syncope occur during initial therapy. Advise to sit or lie down when symptoms of lowered BP occur and to rise carefully from a sitting or lying position. Bothersome dizziness, lightheadedness, or palpitations should be reported to physician.

Tell patients that drowsiness or somnolence can occur, requiring caution in people who must drive or operate heavy machinery.

Laboratory Tests: Small but statistically significant decreases in hematocrit, hemoglobin, WBC, total protein and albumin were observed in clinical trials. The magnitude of decreases did not worsen with time. These findings suggest the possibility of hemodilution.

Drug Interactions: In controlled trials, terazosin was added to diuretics, and several beta adrenergic blockers, no unexpected interactions were observed. Terazosin has also been used concomitantly without interaction in at least 50 patients on the following: analgesic/anti-inflammatory (acetaminophen, aspirin, codeine, ibuprofen, indomethacin), 2) antibiotic (erythromycin, trimethoprim and sulfamethoxazole), 3) anticholinergic/sympathomimetic (phenylephrine HCl, phenylpropanolamine HCl, pseudoephedrine HCl), 4) antiparkinsonian (L-DOPA), 5) antihistamines (chlorpheniramine), 6) cardiovascular agents (atenolol, hydrochlorothiazide, methylclothiazide, propranolol), 7) corticosteroids, 8) gastrointestinal agents (antacids), 9) hypoglycemics; 10) sedatives and tranquilizers (diazepam).

Carcinogenesis, Mutagenesis, Impairment of Fertility: HYTRIN was devoid of mutagenic potential when evaluated *in vivo* and *in vitro*.

HYTRIN, administered in feed to rats at doses of 8, 40, and 250mg/kg/day for 2 yrs., was associated with a statistically significant increase in benign adrenal medullary tumors of male rats exposed to the 250mg/kg dose. This dose is 635 X max recommended human dose (20mg/55kg). Female rats were unaffected. HYTRIN was not oncogenic in mice when administered in feed for 2 yrs. at a maximum tolerated dose of 32mg/kg/day.

The absence of mutagenicity in a battery of tests, of tumorigenicity of any cell type in the mouse carcinogenicity assay, of increased total tumor incidence in either species, and of proliferative adrenal lesions in female rats, suggests a male rat species-specific event. Numerous other diverse pharmaceutical and chemical compounds have been associated with these tumors in male rats without supporting evidence for carcinogenicity in man.

Effects on fertility were assessed in a standard fertility/reproductive performance study in which male and female rats were administered oral doses of 8, 30 and 120mg/kg/day. Four of 20 male rats given 30mg/kg and 5 of 19 male rats given 120mg/kg failed to sire a litter. Testicular weights and morphology were unaffected. Vaginal smears at 30 and 120mg/kg/day appeared to contain less sperm than smears from control matings and good correlation was reported between sperm count and subsequent pregnancy.

Oral use for 1 or 2 yrs. elicited a statistically significant increase in testicular atrophy in rats exposed to 40 and 250mg/kg/day, but not in rats exposed to 8mg/kg/day (> 20 X max recommended human dose). Testicular atrophy was observed in dogs dosed with 300mg/kg/day (> 800 X max recommended human dose) for 3 months but not after 1 yr. when dosed with 20mg/kg/day. This lesion has also been seen with Minipress®.

Pregnancy: Teratogenic effects: Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women and the safety of terazosin in pregnancy has not been established. HYTRIN is not recommended during pregnancy unless potential benefit justifies potential risk to mother and fetus.

Nonteratogenic effects: In a peri- and post-natal development study in rats, significantly more pups died in the group dosed with 120mg/kg/day (> 300 X max recommended human dose) than in the control group during the 3-week post partum period.

Nursing Mothers: It is not known whether terazosin is excreted in breast milk; therefore, exercise caution when administering terazosin to a nursing woman.

Pediatric Use: Safety and effectiveness have not been determined.

ADVERSE REACTIONS: The prevalence of adverse reactions has been ascertained from 14 placebo-controlled studies conducted primarily in the U.S. The studies involved once-a-day administration of terazosin as monotherapy or in combination with other antihypertensive agents, at doses ranging from 1 to 40mg. All adverse events reported during these studies were recorded as adverse reactions. Adverse events where the prevalence rate in the terazosin group was at least 2% and was greater than the prevalence rate for the placebo group, or where the reaction is of particular interest are summarized below. Only asthenia, blurred vision, dizziness, nasal congestion, nausea, peripheral edema, palpitations, and somnolence were significantly ($p < 0.05$) more common in patients receiving terazosin than in patients receiving placebo. Other events include [%TERAZOSIN-%PLACEBO]: asthenia (11.3%-4.3%), back pain (24%-1.2%), blurred vision (1.6%-0%), depression (0.3%-0.2%), dizziness (19.3%-7.5%), dyspnea (3.1%-2.4%), edema (0.9%-0.6%), headache (16.2%-15.8%), impotence (1.2%-1.4%), libido decreased (0.6%-0.2%), nasal congestion (5.9%-3.4%), nausea (4.4%-1.4%), nervousness (2.3%-1.8%), pain extremities (3.5%-3%), palpitations (4.3%-1.2%), paresthesia (2.9%-1.4%), peripheral edema (5.5%-2.4%), postural hypotension (1.3%-0.4%), sinusitis (2.6%-1.4%), somnolence (5.4%-2.8%), tachycardia (1.9%-1.2%), weight gain (0.5%-0.2%).

Adverse reactions were usually mild or moderate in intensity but sometimes were serious enough to interrupt treatment. Adverse reactions that were most bothersome as judged by being reported as reasons for discontinuation of therapy by at least 0.5% of the terazosin group and being reported more often than in the placebo group [%TERAZOSIN-%PLACEBO] are: asthenia (1.6%-0%), blurred vision (0.6%-0%), dizziness (3.1%-0.4%), dyspnea (0.9%-0.6%), headache (1.3%-1%), nasal congestion (0.6%-0%), nausea (0.8%-0%), palpitations (1.4%-0.2%), paresthesia (0.8%-0.2%), peripheral edema (0.6%-0%), postural hypotension (0.5%-0%), somnolence (0.6%-0.2%), syncope (0.5%-0.2%), tachycardia (0.6%-0%).

Additional adverse reactions have been reported in clinical studies but are not distinguishable from symptoms that might have occurred in the absence of exposure to terazosin. The following additional adverse reactions were reported by at least 1% of 1987 patients who received terazosin in clinical studies or during marketing experience: abdominal pain, abnormal vision, anxiety, arrhythmia, arthralgia, arthritis, bronchitis, chest pain, cold symptoms, conjunctivitis, constipation, diarrhea, dry mouth, dyspepsia, epistaxis, facial edema, fever, flatulence, flu symptoms, gout, increased cough, insomnia, joint disorder, myalgia, neck pain, pharyngitis, pruritus, rash, rhinitis, shoulder pain, sweating, tinnitus, urinary frequency, urinary tract infection, vasodilation, vomiting.

DOSEAGE AND ADMINISTRATION: Dose and dose interval (12 or 24 hrs.) should be adjusted according to BP response.

Initial Dose: 1mg at bedtime. Observe the initial dosing regimen strictly to minimize potential for severe hypotensive effects.

Subsequent Doses: Slowly increase dose to achieve desired BP response. Usual dose range is 1mg to 5mg once a day. Some patients may benefit from doses up to 20mg/day. Doses over 20mg do not appear to provide further BP effect. Doses over 40mg have not been studied. Monitor BP at the end of dosing interval to assure control is maintained. It may be helpful to measure BP 2-3 hrs. after dosing to see if maximum and minimum responses are similar, and to evaluate symptoms which can result from excessive hypotensive response. If response is substantially diminished at 24 hrs., consider an increased dose or b.i.d. regimen. If administration is discontinued for several days or longer, reinstitute therapy using initial dosing regimen. In clinical trials, except for the initial dose, the dose was given in the morning.

Use With Other Drugs: Caution should be observed when terazosin is administered concomitantly with other antihypertensive agents (e.g., calcium antagonists) to avoid the possibility of significant hypotension. When adding a diuretic or other antihypertensive agent, dosage reduction and retitration may be necessary.

August, 1987 Abbott Health Care Products, Inc. North Chicago, IL 60064

7083834

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3. Data on file. Abbott Pharmaceuticals.
4. Oeger G. Effect of terazosin on serum lipids. *Am J Med* 1986;80 (suppl 5B) 82-85.

7083834

OBITUARIES

****Coggeshall, Lowell T.,** Foley, Alabama (formerly of Chicago), died November 11, 1987 at the age of 86. Dr. Coggeshall was a 1928 graduate of the Indiana University School of Medicine, Indianapolis.

***Durso, August J.,** Glenview, died November 4, 1987 at the age of 65. Dr. Durso was a 1944 graduate of the Loyola University Stritch School of Medicine, Maywood.

****Filipiak, Marion Joseph,** Chicago, died March 6, 1987 at the age of 87. Dr. Filipiak was a 1925 graduate of the Loyola University Stritch School of Medicine, Maywood.

****Jacobs, William F.,** River Forest, died November 10, 1987 at the age of 78. Dr. Jacobs was a 1934 graduate of the University of Illinois College of Medicine, Chicago.

****Lukaszewski, Edwin J.,** Chicago, died October 18, 1987 at the age of 80. Dr. Lukaszewski was a 1933 graduate of the University of Health Sciences/Chicago Medical School.

****Price, Robert G.,** Normal, died May 7, 1987 at the age of 78. Dr. Price was a 1935 graduate of the Northwestern University Medical School, Chicago.

****Rubovits, Frank E.,** Chicago, died November 10, 1987 at the age of 77. Dr. Rubovits was a 1936 graduate of the Rush Medical College, Chicago.

****Scott, Gordon H.,** Chicago, died November 7, 1987 at the age of 88. Dr. Scott was a 1927 graduate of the McGill University Faculty of Medicine, Montreal, Canada.

***Spencer, Warren F.,** Evanston, died November 10, 1987 at the age of 66. Dr. Spencer was a 1955 graduate of the Northwestern University Medical School, Chicago.

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CONTRAINDICATIONS: Hypersensitivity to trimethoprim or sulfonamides; documented megaloblastic anemia due to folate deficiency; pregnancy at term and during the nursing period; infants less than two months of age.

WARNINGS: FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS.

BACTRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. Clinical signs, such as rash, sore throat, fever, pallor, purpura or jaundice, may be early indications of serious reactions. In rare instances a skin rash may be followed by more severe reactions, such as Stevens-Johnson syndrome, toxic epidermal necrolysis, hepatic necrosis or serious blood disorder. Perform complete blood counts frequently.

BACTRIM SHOULD NOT BE USED IN THE TREATMENT OF STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have a greater incidence of bacteriologic failure when treated with Bactrim than with penicillin.

PRECAUTIONS: *General:* Give with caution to patients with impaired renal or hepatic function, possible folate deficiency (e.g., elderly, chronic alcoholics, patients on anticonvulsants, with malabsorption syndrome, or in malnutrition states) and severe allergies or bronchial asthma. In glucose-6-phosphate dehydrogenase deficient individuals, hemolysis may occur, frequently dose-related.

Use in the Elderly: May be increased risk of severe adverse reactions in elderly, particularly with complicating conditions, e.g., impaired kidney and/or liver function, concomitant use of other drugs. Severe skin reactions, generalized bone marrow suppression (see WARNINGS and ADVERSE REACTIONS) or a specific decrease in platelets (with or without purpura) are most frequently reported severe adverse reactions in elderly. In those concurrently receiving certain diuretics, primarily thiazides, increased incidence of thrombocytopenia with purpura reported. Make appropriate dosage adjustments for patients with impaired kidney function (see DOSAGE AND ADMINISTRATION).

Use in the Treatment of Pneumocystis Carinii Pneumonitis in Patients with Acquired Immunodeficiency Syndrome (AIDS): Because of unique immune dysfunction, AIDS patients may not tolerate or respond to Bactrim in same manner as non-AIDS patients. Incidence of side effects, particularly rash, fever, leukopenia, with Bactrim in AIDS patients treated for *Pneumocystis carinii* pneumonitis reported to be greatly increased compared with incidence normally associated with Bactrim in non-AIDS patients.

Information for Patients: Instruct patients to maintain adequate fluid intake to prevent crystalluria and stone formation.

Laboratory Tests: Perform complete blood counts frequently; if a significant reduction in the count of any formed blood element is noted, discontinue Bactrim. Perform urinalyses with careful microscopic examination and renal function tests during therapy, particularly for patients with impaired renal function.

Drug Interactions: In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombocytopenia with purpura has been reported. Bactrim may prolong the prothrombin time in patients who are receiving the anticoagulant warfarin. Keep this in mind when Bactrim is given to patients already on anticoagulant therapy and reassess coagulation time. Bactrim may inhibit the hepatic metabolism of phenytoin. Given at a common clinical dosage, it increased the phenytoin half-life by 39% and decreased the phenytoin metabolic clearance rate by 27%. When giving these drugs concurrently, be alert for possible excessive phenytoin effect. Sulfonamides can displace methotrexate from plasma protein binding sites, thus increasing free methotrexate concentrations.

Drug/Laboratory Test Interactions: Bactrim, specifically the trimethoprim component, can interfere with a serum methotrexate assay as determined by the competitive binding protein technique (CBPA) when a bacterial dihydrofolate reductase is used as the binding protein. No interference occurs if methotrexate is measured by a radioimmunoassay (RIA). The presence of trimethoprim and sulfamethoxazole may also interfere with the Jaffe alkaline picrate reaction assay for creatinine, resulting in overestimations of about 10% in the range of normal values.

Carcinogenesis, Mutagenesis, Impairment of Fertility: *Carcinogenesis:* Long-term studies in animals to evaluate carcinogenic potential not conducted with Bactrim. *Mutagenesis:* Bacterial mutagenic studies not performed with sulfamethoxazole and trimethoprim in combination. Trimethoprim demonstrated to be nonmutagenic in the Ames assay. No chromosomal damage observed in human leukocytes *in vitro* with sulfamethoxazole and trimethoprim alone or in combination; concentrations used exceeded blood levels of these compounds following therapy with Bactrim. Observations of leukocytes obtained from patients treated with Bactrim revealed no chromosomal abnormalities. *Impairment of Fertility:* No adverse effects on fertility or general reproductive performance observed in rats given oral dosages as high as 70 mg/kg/day trimethoprim plus 350 mg/kg/day sulfamethoxazole.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Trimethoprim and sulfamethoxazole may interfere with folic acid metabolism; use during pregnancy only if potential benefit justifies potential risk to fetus. Nonteratogenic Effects: See CONTRAINDICATIONS section.

Nursing Mothers: See CONTRAINDICATIONS section.

Pediatric Use: Not recommended for infants under two months (see INDICATIONS and CONTRAINDICATIONS sections).

ADVERSE REACTIONS: Most common are gastrointestinal disturbances (nausea, vomiting, anorexia) and allergic skin reactions (such as rash and urticaria). **FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS (SEE WARNINGS SECTION).**

Hematologic: Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, neutropenia, hemolytic anemia, megaloblastic anemia, hypoprothrombinemia, methemoglobinemia, eosinophilia. *Allergic Reactions:* Stevens-Johnson syndrome, toxic epidermal necrolysis, anaphylaxis, allergic myocarditis, erythema multiforme, exfoliative dermatitis, angioedema, drug fever, chills, Henoch-Schoenlein purpura, serum sickness-like syndrome, generalized allergic reactions, generalized skin eruptions, photosensitivity, conjunctival and scleral injection, pruritus, urticaria and rash. *Periarteritis nodosa* and systemic lupus erythematosus have been reported. *Gastrointestinal:* Hepatitis (including cholestatic jaundice and hepatic necrosis), elevation of serum transaminase and bilirubin, pseudomembranous enterocolitis, pancreatitis, stomatitis, glossitis, nausea, emesis, abdominal pain, diarrhea, anorexia. *Genitourinary:* Renal failure, interstitial nephritis, BUN and serum creatinine elevation, toxic nephrosis with oliguria and anuria, crystalluria. *Neurologic:* Aseptic meningitis, convulsions, peripheral neuritis, ataxia, vertigo, tinnitus, headache. *Psychiatric:* Hallucinations, depression, apathy, nervousness. *Endocrine:* Sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents; cross-sensitivity may exist. Diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. *Musculoskeletal:* Arthralgia, myalgia. *Miscellaneous:* Weakness, fatigue, insomnia.

DOSAGE AND ADMINISTRATION: Not recommended for use in infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN: Usual adult dosage for urinary tract infections is one DS tablet, two tablets or four teaspoonfuls (20 ml) *b.i.d.* for 10 to 14 days. Use identical daily dosage for 5 days for shigellosis. *Recommended dosage for children* with urinary tract infections or acute otitis media is 8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses every 12 hours for 10 days. Use identical daily dosage for 5 days for shigellosis. *Renal Impaired:* Creatinine clearance above 30 ml/min, give usual dosage, 15-30 ml/min, give one-half the usual regimen, below 15 ml/min, use not recommended.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS: Usual adult dosage is one DS tablet, two tablets or four teasp. (20 ml) *b.i.d.* for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS: Recommended dosage is 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

HOW SUPPLIED: DS (double strength) Tablets (160 mg trimethoprim and 800 mg sulfamethoxazole)—bottles of 100, 250 and 500, Tel-E-Dose® packages of 100, Prescription Paks of 20. Tablets (80 mg trimethoprim and 400 mg sulfamethoxazole)—bottles of 100 and 500, Tel-E-Dose® packages of 100, Prescription Paks of 40. Pediatric Suspension (40 mg trimethoprim and 200 mg sulfamethoxazole per teasp.)—bottles of 100 ml and 16 oz (1 pint). Suspension (40 mg trimethoprim and 200 mg sulfamethoxazole per teasp.)—bottles of 16 oz (1 pint).

STORE TABLETS AT 15°-30°C (59°-86°F) IN A DRY PLACE PROTECTED FROM LIGHT. STORE SUSPENSIONS AT 15°-30°C (59°-86°F) PROTECTED FROM LIGHT.

"I Quit Clinics"

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state.

The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 1440 W. Washington Blvd., Chicago 60607. Telephone (312) 243-2000.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

In addition, the American Cancer Society provides Fresh Start clinic training anywhere in Illinois for hospitals and industries. Educational materials, pamphlets, posters, films and training can also be obtained at no charge. For information, contact your local ACS office, or the Illinois Division, Inc., at 37 South Wabash Ave., Chicago 60603; (312) 372-0471.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

February	Our Lady of Mercy Hospital	Dyer, IN
February 1	St. Mary Medical Center	Hobart, IN
February 2	Rush North Shore Med. Ctr.	Skokie
February 2	VA Lakeside Medical Ctr.	Chicago
February 9	Carle Clinic	Urbana
March 1	VA Lakeside Medical Ctr.	Chicago
March 1	Rush North Shore Med. Ctr.	Skokie
March 8	Carle Clinic	Urbana
April 4	Alexian Bros. Med. Ctr.	Elk Grove



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

ABSTRACTS OF ACTIONS

November 6, 1987

Hyatt Oak Brook Hotel

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and

are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

IDPA MEDICAL QUALITY REVIEW COMMITTEE

The Board reviewed a report from the Third Party Payment Processes Committee (TPPPC) on IDPA Medical Quality Review Committee (MQRC) issues. The IDPA is mandated to review physicians and recipients enrolled in the Medical Assistance Program to guard against fraud and abuse, and to ensure that recipients receive necessary medical care. Previous efforts by IDPA in monitoring this program were primarily focused on financial rather than quality of care issues and led to the belief by some physicians that the recoupment of money was the purpose rather than a side effect of the program.

ISMS urged IDPA to refocus its review in the Medical Assistance Program toward quality of care issues. IDPA has developed its MQRC to conduct these refocused reviews. MQRC is entirely comprised of Illinois physicians, most of whom are nominated by ISMS upon the recommendation or endorsement of the local county medical society. While the fundamental process of MQRC review seems to involve appropriate medical peer review activity, the TPPPC made several suggestions to improve the process of both MQRC and TPPPC.

The Board agreed to: (1) Ask IDPA to formalize the process of allowing the Medical Quality Review Committee to recommend CME as an option for corrective action against a physician under appropriate circumstances; and (2) Authorize the chairman of the Board to appoint an advisory committee to the Third Party Payment Processes Committee consisting of physicians with a significant volume of IDPA patients.

IMJ ADVERTISING GUIDELINES

The Board reviewed a report from the Publications Committee regarding classified advertising nomenclature and a proposed policy change. Confusion has been reported resulting from use of the generic term "doctor" in classified advertisements by non-MDs. Legal counsel has advised that a non-discriminatory policy regarding nomenclature would address these concerns without undue burden on advertisers. The Board approved an amendment by addition to the IMJ advertising guidelines as follows: *Illinois Medical Journal*

advertisers who are either licensed under the Medical Practice Act of 1987 or who are seeking to place a classified ad for a physician's position in their practice or setting, and who wish to be identified in classified copy, must use their legal names with initials indicating class of licensure. The generic terms "Doctor" or "Dr." will not be acceptable.

CME ACCREDITATION FEES

Component societies became eligible to have their CME programs approved for Category 1 credit through the ISMS Committee on CME Activities in April 1987. It is no longer necessary for component societies to seek independent accreditation as they are already covered under ISMS' accredited sponsor status. The Board approved: (1) Deletion of previous fee structures; and (2) The following amended fee structure for component societies:

CME Accreditation Fees

(a) Registration Fee—\$200

A one-time fee payable upon submission of the "Preliminary Questionnaire." Institutions affected by the 12-month rule must pay the registration fee again.

(b) Survey Fee—Varies according to size and type of applicant:

(1) Hospitals or other medical organizations of 49 or fewer members*—\$750

(2) All other applicants—\$1000

This fee must accompany the accreditation application.

*"Member" refers to: (1) For a hospital, members of the attending medical staff, whatever rank or status they hold (active, associate, provisional, senior, etc.), whether employed by a hospital full-time or part-time, or office-based or hospital-based; (2) For other organizations, active members however defined by the organization, (e.g. for specialty society, all paying regular dues). *In both cases*, exclude students, residents, consultants, courtesy and emeritus members, honorary and corresponding members.

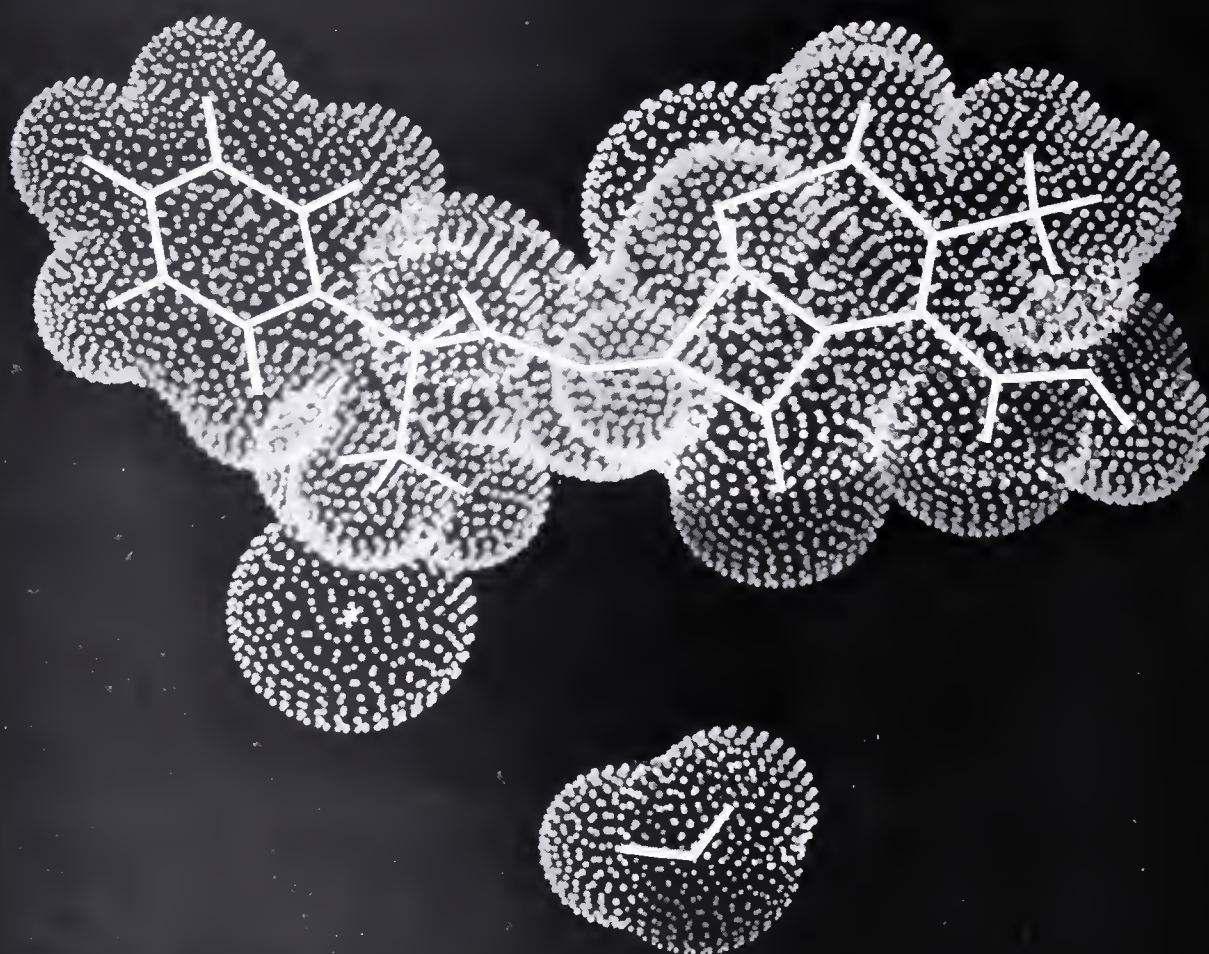
(Continued on page 48)

ANNOUNCING

NEW

KEFTABTM

cephalexin hydrochloride monohydrate



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Division of Eli Lilly and Company
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Mfd by Eli Lilly Industries, Inc
Carolina, Puerto Rico 00630

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Computer-generated molecular
structure of cephalexin
hydrochloride monohydrate

THE INFORMED PHYSICIAN

THE INFORMED PHYSICIAN KNOWS WHAT QUESTIONS TO ASK, WHAT ISSUES TO RESOLVE AND WHEN TO CONSULT AN ATTORNEY, ACCOUNTANT OR ACTUARY WHEN CONSIDERING CONTRACTING WITH ALTERNATIVE DELIVERY SYSTEMS. THE ISMS OFFICE OF CONTRACTUAL SERVICES PRESENTS "THE INFORMED PHYSICIAN" AS AN EDUCATIONAL TOOL DESIGNED TO ILLUSTRATE, THROUGH REAL-LIFE SITUATIONS, THE SIGNIFICANT LEGAL AND ECONOMIC ISSUES WHICH FREQUENTLY ACCOMPANY CONTRACTS FOR THE DELIVERY OF HEALTH CARE, AND TO ALERT PHYSICIANS OF WAYS IN WHICH CONTRACTS MAY AFFECT THE PRACTICE OF MEDICINE.

Will You and Your Contract Meet in Court?

By JUDEE GALLAGHER, J.D., AND SAUL J. MORSE, J.D.,
CHICAGO AND SPRINGFIELD

In a medium-sized midwestern town, a trial court considers the malpractice liability of two defendants, a general practitioner and an HMO. It is alleged that in August of 1985, the plaintiff first informed her physician of bright red vaginal bleeding accompanied by mucous discharge. Symptoms continued until June of 1986, when the plaintiff went to the emergency room of the local community hospital. There she was admitted with a diagnosis of metastatic cervical cancer.

The plaintiff claims that the defendants are jointly liable for the physician's failure to make a prompt specialty referral and to properly perform diagnostic tests, including a PAP smear. The allegations state that during the intervening 10 months, the plaintiff saw her physician six times and explained her symptoms. The physician performed a vaginal exam once and prescribed antibiotics. The plaintiff

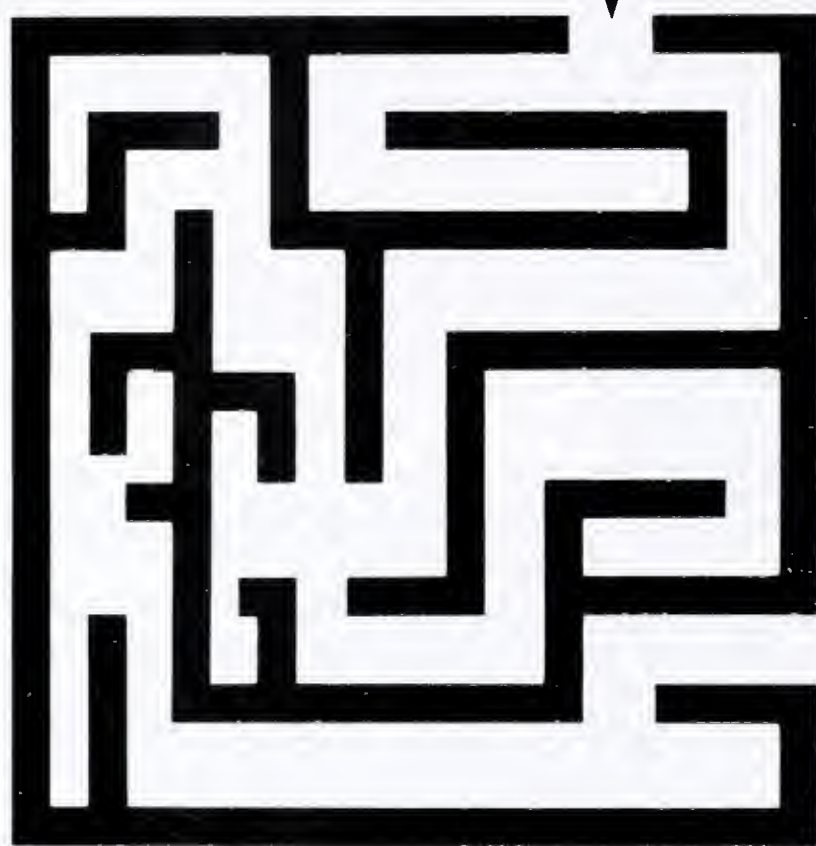
twice specifically requested a referral to her gynecologist and was refused.

Similar malpractice cases where the HMO and the primary care physician are alleged to be jointly liable for the physician's failure to properly conduct diagnostic testing and promptly refer for specialty care are pending in Illinois and across the nation. This case is of particular interest to health care attorneys. Physicians may find it to be an instructive illustration of how and why a physician's contract can become part of a malpractice lawsuit. The argument is that two common provisions in HMO/physician contracts were factors causing the defendants' negligence. The focus is on the lynchpins of cost containment: utilization control and compensation methods.

In this example, plaintiff attorneys reasoned that prior authorization and restricted referral require-

ments of the contract, combined with the method of compensation, constituted an unethical medical practice and amounted to a violation of the state HMO Act. That law obligates the HMO to provide needed services regardless of extent, frequency, or nature.

The contract in this case was a "gatekeeper" model. The primary care physician controlled referrals to specialists, subject to contractual restrictions which included prior authorization and other limitations. Physicians were paid a capitation fee (a fixed amount per enrollee per month regardless of utilization). Any monies remaining in a fund designated to pay for referrals, lab work, diagnostic tests, and hospitalization were split by the physicians and the HMO. It was argued that the contractual relationship produced a disincentive to refer and order diagnostic tests. The contract was said to have "chilled, inhibited



CONTRACT REVIEWS

HMO
PPO
IPA

Before
you
sign,
negotiate

Before
you
negotiate
review

The ISMS Office of Contractual Services reviews HMO, PPO and IPA contracts for members. The cost is \$100 per review.

Reviews do not constitute legal advice. They provide a working document which highlights key issues, such as malpractice coverage, reimbursement concerns and practice limitations.

For further information contact:

ISMS Office of Contractual Services
Twenty North Michigan Ave., Suite #700
Chicago, Illinois 60602

(312) 782-1654 or (800) 782-ISMS

and thwarted" the accepted standards of medical practice, imposing an impermissible interference in the physician/patient relationship.

Regardless of the merits of the plaintiff's arguments or the truth of her allegations, a physician's contract for the delivery of health services has become pertinent in a malpractice lawsuit. Contractual cost containment mechanisms such as utilization review and various compensation methods were likely to be scrutinized.

Other Arenas for Scrutiny

The malpractice case is not the only setting in which a physician's contract will be examined. Just as patients sue HMOs for failure to pay hospital bills, disputes between HMOs and physicians regarding return of monies from, or charges made against, the physicians' withheld accounts may spark legal action or bring the parties to binding arbitration.

Contract termination also engenders litigation. Most contracts automatically renew unless specific advance notice of termination is given. But most contracts also permit termination if the physician's utilization rate or adherence to utilization review mandates is unsatisfactory in the eyes of the HMO. Notice dates can easily be overlooked and breach of contract suits involving utilization may be the most troublesome type of breach of contract claim.

To reduce the chances that your contract will be scrutinized by the courts or an arbitrator, you must review it thoroughly. Before you sign or negotiate a contract, you or your personal attorney or financial advisor should understand the legal and financial implications of every provision as completely as the HMO, PPO or IPA attorney who wrote it. Think of the original contract as a draft for discussion and negotiation, not a final document. Remember: all terms are negotiable, not only price. Can you fulfill your contractual obligations without compromising your primary role as the patient's advocate? Define your "bottom line." What provisions are unacceptable? Where can you compromise? What counterproposals will eliminate

your reservations about the contract and also be acceptable to the HMO? In other words, what are your conclusions after reviewing the contract?

Comprehensive review centers on clarity, logic and liability.

Clarity: Are special terms defined concisely?

If not, it's likely that the specific obligations of the contract will be confusing and ambiguous. For example, if covered services are defined in terms of a purchaser agreement which is not attached to the contract, you do not know what services are covered for the purposes of payment and utilization review. How can you evaluate the financial impact of the contract and the extent of required utilization review?

Logic: Does the contract make sense as a whole?

This question was much easier to answer a few years ago, when the typical PPO contract was five pages at most and the typical HMO contract was 10 pages or less. Today it is not unusual for an HMO, PPO or "hybrid" contract to be 25 to 40 pages. Consider this contract, which might be fairly typical:

Page 3—"Physician shall perform covered services in accordance with the standards of medical procedures applicable to physician's other patients."

Page 7—"Physician is responsible for maintaining the physician/patient relationship and HMO shall not interfere in the physician/patient relationship."

Page 18—"Physician is solely responsible for the quality of services rendered and shall not deny covered services because of the source of payment."

These terms present no problems in and of themselves, but they are often accompanied by obligations such as these, which appear to limit the physician's clinical decision making:

Page 33—"Physician shall be bound by all utilization review decisions, policies and procedures. Failure to comply may result in contract termination and financial sanction and reduced reimbursement." (The

clinical criteria used by the reviewers are not stated in the contract). *Page 35*—(Attachment A) "Physician is bound by HMO's utilization review decisions and takes responsibility for the HMO contract terms regarding preadmission review and other measures designed to achieve more cost-effective care." (Should the physician be responsible for the HMO's cost containment program?)

Consider the design of this compensation arrangement, given that the various components may well be scattered helter-skelter throughout a 30 page document. The primary care physician is paid on a capitation basis. Twenty percent of capitation is withheld in a risk pool to be used if the referral and hospital funds are exhausted. Because actuarial assumptions are unstated, it's not possible to determine whether specialty care and hospitalization have been adequately funded. The capitation table amount is not useful because it doesn't show what services are covered under any particular plan. The primary care physician can choose to provide "specialty services" on a capitated basis, but there is no way of knowing how the stated capitation amount or the funding of the specialty fund will be affected if physicians choose to do this. The HMO can change the capitation amount depending on "actuarial success" or other "relevant factors," none which are defined. Prior notice to and the consent of the physician are not required.

It is unclear whether capitation changes automatically occur as premiums are increased. Additional services may be added without physician notice or approval and without capitation adjustments. Only the physician is at risk for capitated physician services. The limit of the amount of stop/loss coverage is not stated, nor is the method of calculation used to reach the threshold amount.

It takes expertise (and sometimes a good deal of time) to cull payment schemes and "standard of care" issues from a long, complex contract. And along with the ascent of the "thick" contract, the introduction of contracts which combine features of HMO, PPO and indem-

nity plans adds to the intricacy of the review process. A working knowledge of the idiosyncracies and issues created by hybrid systems is needed. Contracts which allow the corporate entity to add a "product line" not yet in existence when the physician becomes a party to the contract also presents special issues.

Liability: What is the impact on your insurance coverage?

No contract review is complete without an exhaustive examination of its impact on the physician's insurance coverage. Does the contract require you to indemnify and hold harmless the HMO, PPO or IPA against liability? Did you know that your malpractice insurance may not cover this exposure? Are you required to participate in activities not covered by your malpractice insurance? Does the contract require that your malpractice company notify the HMO or PPO of cancellation, nonrenewal or a material change in coverage? Will your company provide this notification? Is your contractor required to carry professional liability insurance? Does their coverage include physician participation on utilization and quality control committees established by the contractor?

Because you're an informed physician who recognizes the complex issues involved in contracts for the delivery of medical care, your first step is to send the contract offered you or your IPA to the ISMS Office of Contractual Services. As a *members-only service*, the office will provide you objective comments on any

HMO, PPO or IPA contract for the nominal fee of \$100. Contract reviews highlight "standard of care," compensation and insurance issues. They pinpoint ambiguous language and inconsistent or contradictory provisions.

The review is a basic tool to help understand the contract. It's a good first step, but never a substitute for careful reading of the contract itself. It's not legal advice and the office cannot recommend that any contract is good or bad and should or shouldn't be signed. Each physician (or physician's corporation or partnership) must make that decision. The informed physician's personal attorney and accountant must be consulted before decisions are made.

Your attorney has undoubtedly explained that when you are considering an Individual Participation Agreement with an HMO, PPO or IPA you may not band together with other physicians to negotiate the contract collectively, because that violates antitrust laws. You can, however, individually negotiate your own contract by yourself or with your personal attorney or financial advisor. ◀

Saul J. Morse, J.D., is the principal of Saul J. Morse & Associates, Ltd., a Springfield law firm concentrating in governmental, health and administrative law. Mr. Morse has been legislative counsel to the Illinois State Medical Society since 1977, and has served as minority legal counsel to the Illinois Senate and a trial attorney before the U.S. Commerce Commission.

Judge Gallagher, J.D., is a Chicago private practice attorney retained by the ISMS Office of Contractual Services since 1985.

LIBRIUM®

chlordiazepoxide HCl/Roche (N)

5-mg, 10-mg, 25-mg capsules

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders; short-term relief of anxiety symptoms, acute alcohol withdrawal symptoms, preoperative apprehension and anxiety. Usually not required for anxiety or tension associated with stress of everyday life. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported after abrupt cessation of extended use of excessive doses are similar to those seen with barbiturates. Milder symptoms reported infrequently when continuous therapy is abruptly ended. Avoid abrupt discontinuation; gradually taper dosage.

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety disorders and symptoms, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl/Roche) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in boxes of 4 reverse-numbered cards of 25, and in boxes containing 10 strips of 10. Libritabs® (chlordiazepoxide/Roche) Tablets, 5 mg and 10 mg—bottles of 100 and 500; 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.



Roche Products Inc.
Manati, Puerto Rico 00701

Do not substitute

Librium®

brand of

chlordiazepoxide HCl/Roche (IV)



Nobody does it better.



Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

Contraindications: There are no known contraindications to the use of 'Tagamet'.

Precautions: While a weak antiandrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlorthalidoxime, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.),

demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly unlikely.

likely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only), and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

Liquid: 300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).

Injection:

Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage® Vials: 300 mg./2 ml. in single-dose, ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl (brand of cimetidine hydrochloride) Injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

* ADD-Vantage® is a trademark of Abbott Laboratories.

BRS-TG-1738

Date of issuance Apr. 1987

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In peptic ulcer:

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Tagamet
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You'll both feel good about it.

RESULTS

The ISMS Contract Review Service

Guiding Physicians through the Maze of Options

The Illinois State Medical Society Contract Review Service is designed to enable physicians to make knowledgeable decisions regarding proposed contracts with alternative delivery systems. The monthly IMJ "Informed Physician" column is a part of that effort. The cornerstone of the program—available to members only—is expert review of proposed contracts.

1957: Dr. Joseph Smith, Sr., has received his M.D. degree and finished a residency in internal medicine. He's rented office space, hung out his shingle in suburban Chicago, and put his medical degree and license on the waiting room wall. He's moved into an area that's beginning to boom, where physicians are needed to take on the growing patient population. Dr. Smith's prospects look bright for a prosperous and fulfilling medical practice and for economic security in the years ahead.

The billing for patients he treats? It's simple. His office assistants just complete the form handed to them by patients. Once it's been mailed to the insurance company, Dr. Smith can expect adequate reimbursement in just a few weeks. And for those who cannot afford Dr. Smith's charges, he works out a reduced fee that they can handle. He sometimes provides care for nothing at all, and feels good about being able to help those in financial trouble.

1987: Dr. Joseph Smith, Jr., is a young physician studying his options for medical practice. With student loans of \$50,000 and no capi-



tal to start up a private practice, he chose to join a multi-specialty group of several young doctors. Patients are a bit sparse, due to the large number of physicians practicing in the immediate vicinity. The medical malpractice bill paid by the group is very high—almost half a million dollars annually.

In the area, several employers and insurance companies have set up PPOs. An independent HMO has also moved into town, soliciting

employees of several local businesses.

Dr. Smith and his partners face hard economic decisions. Can they maintain their patient base without participating in the various PPO and HMO arrangements? That looks doubtful. But more importantly, what do the proposed contracts actually mean for their everyday practice of medicine? How will the contracts affect the financial status and the clinical independence of Dr. Smith and his partners? Regardless of the contract, ethical and legal responsibility for the exercise of good medical judgment remains with him and his partners. But how can he assure that the decision-making roles assumed by HMOs, PPOs and IPAs do not compromise the delivery of good quality medicine? Will the "capitation" provide sufficient monies to cover the actual cost of medical services and overhead? How will the contract affect medical malpractice liability? And just what administrative machinations will the group be forced to endure when requesting referrals or specialized treatment for patients?

"This sure isn't the medicine my father described," thought Dr. Smith, Jr., as he reviewed the contract options before him.

Modern Practice: Tough Choices

Times have drastically changed for practicing physicians in Illinois and throughout our nation. No

longer is medicine merely a highly-regarded profession. It is also a business requiring adroit financial management.

The business side of medicine also holds important implications for the health of patients. New rules by HMOs, PPOs, IPAs and other complex health care financing arrangements can set up barriers to patient care. By making physicians the "gatekeepers," some systems impose a heavy burden. Required prior authorization for physician services, diagnostic tests, lab work, and hospitalization, along with restricted referrals to specialists and other mandates are often effective dollar-savers for health care

payors. But they can be danger traps for physicians and patients ignorant of contract language—and of what it actually means to the daily practice of medicine.

That is the reason that your state medical society established an Office of Contractual Services two years ago. ISMS had received a steadily growing number of calls about what certain contract "legal-ese" really meant, how it could be changed to better mesh with the practicalities of treating patients, and whether newly-sprouting PPOs, HMOs and IPAs could virtually dictate a contract's terms and conditions to prospective physician members.

Since its genesis over two years ago, the Office has handled well over 1,000 requests for contract reviews from our 17,000 members. We believe we have reviewed every different type of contract offered in the state. While ISMS cannot provide specific legal advice, or recommend whether or not a doctor should sign a particular contract, we are able to provide a road map for understanding the complex legal and economic clauses which may bode trouble in your practice. That's what ISMS' Office of Contractual Services is all about: guideposts through the maze of options.

The future prognosis: contracts

Common Issues Which Detour Physicians

The utilization review program of a PPO requires mandatory second opinions, prior authorization, concurrent review, length of stay assignment, discharge planning, and retrospective review. *Query:*

- If the physician complies with the utilization review process during the patient's course of treatment, is there any guarantee that payment of the physician's fees will *not* be denied during retrospective review?

* * *

A contract offered the ABC Multi-Specialty Group states that the HMO will make prompt payment after receipt of properly completed claims forms. After the HMO and the negotiating committee for the group agree on a definition of a "properly" completed claim form, the committee asks what is meant by "prompt" payment. The HMO representative tells the group that the HMO has an excellent reputa-

tion for payment within 30 days.

Query:

- How does the HMO define "prompt payment" and "proper completion?"

Because the written contract is intended to represent the complete and final agreements of the parties, any other agreement, oral or written, that is made during negotiations and is not made a part of the contract, is generally not binding. It is an important and good business practice to have the clarification of vague and ambiguous terms written into the contract.

* * *

Two PPO contracts await a young physician's review. Contract A states: "PPO shall pay physician . . ." Contract B reads: "PPO shall *arrange* for physician to be compensated by payor . . ." *Query:*

- In Contract B, the PPO has no responsibility for paying the physician. Does Contract B obli-

gate the PPO to include in its PPO/payor contracts a provision that requires the payor to directly pay the physician?

- Is the physician required to continue to provide services if the PPO (Contract A) or payor (Contract B) fails to make payments as they become due?

* * *

According to the contract offered to the IPA, the IPA must provide or arrange for the provision of covered services to all *eligible* subscribers. *Query:*

- Is the plan required to provide the IPA with current eligibility information and prompt eligibility verification?
- Is the plan obligated to pay for services rendered to patients identified as eligible and discovered later to have been ineligible? ◀

More Detours

A young physician is considering contracts from two HMOs and is favoring Contract A over B because the capitation rates in Contract A are higher. *Query:*

- Is the cost of stop/loss insurance deducted from the capitation fee under both contracts?
- Does Contract A require the physician to provide more expensive services?
- Is the same percentage of the capitation withheld under both contracts and distributed to the physician under similar circumstances?

- Is interest paid on both the withheld amounts?

* * *

An IPA is considering the termination provisions under a capitation contract. The contract provides that the IPA must continue to provide services to current enrollees after contract termination either for an additional 12 months or until the plan is terminated, whichever occurs first. The IPA is examining various payment options for care rendered during this "extension period." *Query:*

- How many enrollees have chosen the IPA as their physician provid-

er?

- When do the enrollee (plan) contracts expire?
- If a continuation of capitation payment is negotiated, will there be enough enrollees to adequately "spread the risk?"
- If a fee for service arrangement is negotiated, will it be a discounted rate or the usual and customary fee? Is payment within a specific period of time guaranteed?

will continue to become more and more complex, with more and more issues that require clarification. Over the last two years, ISMS' Office of Contractual Services has seen many five and ten page contracts blossom into 25 and 40 page tomes. Physicians must be cautious, because new language, embodying new cost containment ideas and creating new kinds of liability exposure, crop up every day in health care contracts. That language may conflict with a doctor's primary and ultimate responsibility to be the patient's advocate. Contract language can also have serious implications for a doctor's medical malpractice and other liability (Editor's Note: see "The Informed Physician," page 13).

Because the ISMS Office of Contractual Services is a well-used, tangible service for our members, ISMS is working hard to keep it available for you. But a greater share of its cost must be borne by those who use the service. Therefore, at the beginning of 1988, a \$100 nominal charge per contract review will be instituted. ISMS sincerely hopes that this cost will not deter our members from requesting contract reviews. They're still a bargain. The service can save your own attorney many hours of costly legal research.

To request a contract review, just send the contract (and its attachments or exhibits), along with any pertinent documents (such as bylaws) to ISMS, Twenty North

Michigan Avenue, Suite 700, Chicago, Illinois 60602. Include a check for \$100, payable to ISMS.

In return, you will receive a prompt, easy-to-understand review which highlights compensation, quality of care and insurance issues. It will pinpoint ambiguous, inconsistent or contradictory language which may warrant clarification and investigation.

Yes, medicine is rapidly changing. It is important for physicians to keep up with the times. The ISMS Office of Contractual Services can help. We can't roll back the clock to the days of Joseph Smith, Sr. But we can help those of you seeking a reasonable path through the maze of alternatives. ◀



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Physician Responsibility in Hospital Patient Discharge

This article is presented to inform physicians about the general nature of their responsibilities for a patient's discharge from the hospital. It is not—nor should it be construed as—legal advice. Physicians should consult their own attorneys for any legal advice necessary to deal with such situations.

Illinois physicians must be aware that the treating physician bears ultimate responsibility for medical considerations upon which a patient's hospital discharge is based. The medical decision to discharge a patient from a hospital must be based on the physician's sound medical judgment, and not on financial or cost containment considerations relating to reimbursement by third parties.

This is the lesson to be learned from the case of *Wickline v. State of California*.¹ In this California case, a patient who had been discharged from the hospital prior to the time the treating physician believed that the patient should have been discharged sued "Medi-Cal" (California's Medical Assistance Program). The patient asked for damages for the amputation of her leg, alleging that it resulted from premature hospital discharge. The patient had entered the hospital for surgery on her leg, based upon a diagnosis that the circulation was obstructed. The patient was eligible for and received medical benefits and hospital coverage under the Medi-Cal program.

Following surgery, the patient continued to experience difficulty with circulation in the leg. Follow-up surgery was done to remove a clot that had formed in the arterial graft. Several days later, yet another surgical procedure was performed in which nerves lying along the spinal column were removed in an attempt to relieve spasms occurring in the leg.

The patient had been scheduled for discharge after ten days in the hospital. The treating physician, on the final day of the patient's approved hospital stay, sought to extend the hospital stay for an additional eight days. The physician believed that further danger of infection or clotting of the aorta required the patient to remain under observation in the hospital. The physician made the request on the proper form to the Medi-Cal office, but it was reduced to four days by the Medi-Cal physician supervising authorizations.

After four days the patient was released from the hospital, but eventually circulation in the leg stopped altogether, the leg became

seriously infected, and the patient returned to the hospital, where the leg was amputated. The patient then filed suit against the State of California, alleging negligence on the part of the supervisory personnel in the Medi-Cal program.

The essence of the court decision (in finding that the state was not liable) was that:

The physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour.

The *Wickline* case had been accepted by the California Supreme Court for review.² The California Supreme Court has withdrawn that acceptance for review, following the change in the composition of the Court after November, 1986. The Appellate Court's decision stands as final.

There are no similar cases on point in Illinois, but Illinois case law has repeatedly established that the treating physician is responsible for the medical care of his patients.³ As in California, a physician who allows the cost containment policies of a third party payor to outweigh his

medical judgment is not likely to escape responsibility for the results.

AMA Reviews Ethics

Recognizing that the *Wickline* situation could become increasingly common, given the growing pressure for cost-consciousness by all those in the health care field, the AMA Council on Ethical and Judicial Affairs rendered an opinion in 1986 stating: "[I]n a situation where the economic interests of the hospital are in conflict with patient welfare, patient welfare takes priority."

However, the physician who is treating a patient covered by a third party payor is usually under an affirmative obligation to hold down costs by limiting the medical care to that which is medically necessary. For example, Section 1156 of the Social Security Act⁴ requires that the participating "health care practitioner" assure that the services and items provided to the patient-beneficiary not only be "of a quality which meets professionally recognized standards of health care," but "be provided economically" and only when "medically necessary." Further, as a logical extension of these requirements, the participating health care provider must be able to satisfactorily document both the necessity and the quality of the health care rendered. The failure to economically provide services (or be able to so document) may lead to exclusion from the program by a peer review organization. Similarly, failure to deliver quality medical services may not only lead to exclusion from the program, but further disciplinary and legal action. The Medicare Peer Review Organization Manual⁵ states that:

Practitioners who discharge patients prematurely from the hospital or who fail to assure the provision of necessary services may be in violation of their obligation to provide services of a quality which meets professionally recognized standards.

It is instructive to look again at the *Wickline* case. The flaw in the treating physician's conduct upon which the Court focused was that:

[The physician] who complies without protest with limitations

Perhaps the proper analysis is that the physician owes the patient the duty to inform him or her of the medical decision, the financial constraints and the alternatives.

imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for the patient's care.

If the "appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overriden [by a third party payor]," in which case the third party payor may also be liable, the physician must not allow his medical opinions to be shaped by those cost containment decisions. In *Wickline*, the treating physician not only failed to press the Medi-Cal evaluator for additional hospital time, but when the coverage ran out, agreed, *on medical grounds*, to discharge the patient. A physician's potential liability is grounded in this type of action.

Perhaps the proper analysis is that the physician owes the patient the duty to inform him or her of the medical decision, the financial constraints and the alternatives. A phy-

final analysis, the physician owes a legal and ethical duty to render care to the patient which meets professional standards. Despite whatever agreements the physician has with third party payors—public or private—this basic responsibility remains.

The attending physician must also be aware of the Medicare rules and procedures which have been developed to determine the extension or continuation of coverage of an in-hospital patient. Ultimately, the peer review organization is responsible for assuring that the applicable Medicare guidelines for claims payments are met. The attending physician, however, is consulted and must be cognizant of his obligation to render a sound medical opinion in the patient's financial and medical interest. The attending physician's medical recommendations should carry substantial weight in the PRO's determination of coverage.

In the final analysis, the physician owes a legal and ethical duty to render care to the patient which meets professional standards.

sician may not be able to require a patient to remain in a hospital, paying out of his own pocket, in the face of third party payor cost containment policies, but the patient should not be allowed to make that decision without having available a responsible medical determination by the treating physician. In the

Admission Versus Continued Stay Denials

The Medicare PRO process distinguishes between denials of admission and denials of continued stay. The hospital utilization review committee may issue an admission denial without the concurrence of the attending physician. In this

case, the patient or the physician may request a further review from the PRO.

In the case of a continued stay, the hospital utilization review committee may only issue a denial with the concurrence of the attending physician. If the attending physician does not concur, the case goes to a PRO reviewer. The decision of this reviewer can be appealed by physician or patient to a separate panel of PRO physicians. In this instance, the PRO process can be used to support the physician's wish to keep the patient in the hospital.

patient's views as to why that patient believes that they are entitled to further Medicare coverage in the hospital.

The hospital must also forward the relevant patient records to the PRO for their review. To encourage promptness by the hospital in forwarding those records, the patient is not penalized for any delay on the part of the hospital. The hospital may not begin to charge the patient until noon of the day following the day upon which the beneficiary received the determination by the PRO. If the PRO rules that the

information from the attending physician. If the PRO cannot reach the attending physician within the tight time frame required for a decision, the PRO must document its attempts and efforts at doing so.

When the attending physician does not concur with a hospital utilization review committee denial, either the attending physician or the patient may appeal to the Crescent Counties Foundation for Medical Care (the PRO for the State).

If the PRO should affirm the hospital's determination of non-coverage, the patient must make a financial decision as to whether to incur personal liability for a continued stay in the hospital. If the attending physician does not concur with the decision, his advice to the patient should continue to be based on medical necessity, not financial considerations. The physician would be well advised to pursue all available avenues of administrative appeal and to thoroughly document all discussions and communications with the PRO and the patient. As the *Wickline* case demonstrates, the physician's advice must be grounded on medical judgments. This properly serves the patient and protects the physician from malpractice liability. ◀

When the attending physician does not concur with a hospital utilization review committee denial, either the attending physician or the patient may appeal to the Crescent Counties Foundation for Medical Care (the PRO for the State).

Upon a written hospital notice of Medicare non-coverage to an in-hospital patient, when given with concurrence of the attending physician, the patient may request a review of the determination of non-coverage. This request must be made to the PRO by noon on the first working day following the date of the receipt of the notice of non-coverage. The patient is encouraged to call the PRO directly. The notice of non-coverage from the hospital utilization review committee must include information to the patient on procedures for requesting a review of that determination. The PRO is required to solicit the

patient is entitled to continuing Medicare coverage, this decision is not eligible for reconsideration, and the patient cannot be held liable for that extended period of coverage.

Upon receipt of relevant information from the patient and the relevant medical records from the hospital, the PRO will review the hospital utilization review committee's notice of non-coverage. This review must be concluded, and the PRO must notify the beneficiary, hospital and attending physician by phone (with written follow-up). The PRO must make every effort to contact and solicit relevant infor-

References

1. 228 Cal. Rptr. 661 (Court of Appeals, 2nd Dist.) (July 30, 1986)
2. *Wickline*, 231 Cal. Rptr. 560 (November 20, 1986)
3. See, e.g. *Magna v. Elie*, 108 Ill.App.3d 1028, 439 N.E. 2d 1319 (2d Dist. 1982)
4. (42 U.S.C. 1320c-5) (Medicare)
5. (Transmittal No. 6, Section 6005, October 1985)

ISMS All Member Conference Recap

Managing Change

More than 300 physicians and auxiliaries gathered at the Hyatt Oak Brook on November 7 to sharpen their skills in risk reduction and broaden their knowledge of the current practice environment. Physicians who attended gave the program high marks for interest, pace and practical knowledge.

"It's a jungle out there," Illinois State Medical Inter-Insurance Exchange (ISMIE) Policyholder Services Committee Chairman Boyd E. McCracken, Sr., M.D., told physicians attending an ISMIE Network breakfast, which kicked off the All Member Conference. That set the tone for a fast-paced day of drama and debate on the modern medical practice arena, particularly as influenced by the professional liability climate. The Network breakfast—and the program as a whole—featured a spirited give-and-take between participants seeking information and speakers who were glad to provide it.

An Audience on Tenterhooks: The Mock Malpractice Trial

ISMS President Edward J. Fesco, M.D., welcomed the members to the first general session, and Illinois State Medical Insurance Services Chairman Robert C. Hamilton, M.D., sketched out the first event, a mock malpractice trial.

Many of the members attending found the trial to be the highlight of the day. A randomly-selected focus



Former White House Spokesman Larry Speakes entertains with anecdotes and educates with tips on public opinion and the media.

group of Illinois citizens acted as jurors; the case was based upon an actual case from ISMIE. Actors played physician defendants, and attorneys Kevin Egan and Phil Harris from the law firm of Winston and Strawn presented the prosecution and defense. Cook County Associate Judge Daniel O'Brien presided.

After presentation of evidence and testimony, the jury adjourned to debate the merits. A videotape of their deliberations later in the day provided enlightening insights into the adjudication process. An audience poll concurred with the jury, exonerating the defendant surgeon and anesthesiologist. But the actual jury vote was close: only a "hung" jury prevented the anesthesiologist from a "guilty" verdict. Nor was the physician audience lenient: many recommended damages.

Many audience members commented that jury debate clearly did not reflect clinical knowledge. "They're nowhere near peers in terms of their medical knowledge," attorney Egan acknowledged. "But that's the way our nation's court



ISMIE Policyholder Services Committee Chairman Boyd E. McCracken, Sr., M.D.: "It's a jungle out there."

system works." Egan nicely summed up the jury system's strength: "The members may not individually be well educated, but collectively their wisdom is awesome."

A Bit of Politics, Then Back to the Books

After a presentation by Illinois State Medical Society Political Action Committee (IMPAC) Chairman George T. Wilkins, Jr., M.D., former Chicago Mayor Jane M. Byrne spoke on the nuts and bolts of grassroots political organizing. Doctors must work hard in the upcoming 1988 campaigns in order to elect legislators who will favor caps on malpractice awards.

Luncheon speaker Larry Speakes, who is former chief spokesman for the White House, gave insight into the role of media in forming public opinion, and in influencing politics.

In the afternoon, loss prevention consultant Debra Phairas outlined typical misconceptions and mishaps leading to professional liability. Then ISMIE Chairman Fred Z. White, M.D., introduced breakout sessions which enabled physicians to meet with members of their specialty groups for hands-on risk reduction seminars.

Enthusied and Encouraged

Physicians left the 1987 All Member Conference armed with new knowledge of the legal system, the political arena and risk management. Most took the time to give thoughtful evaluations—almost all of which sought similar programs from the Society in years to come.



ISMIS Chairman Robert C. Hamilton, M.D., briefs physicians on the mock malpractice trial.



Former ISMS President Morgan M. Meyer, M.D., sparks debate.



"Physician defendants" confer with counsel.



Here Today. Here Tomorrow.

Today, most commercial professional liability insurers have abandoned the Illinois market. But there's still one company writing malpractice coverage up to \$2 million per incident with a \$4 million aggregate—the Illinois State Medical Inter-Insurance Exchange.

The Exchange is the only malpractice insurer in Illinois that is owned and operated by physicians. As such, we are totally committed to meeting the insurance needs of our policyholders. And we intend to be there as long as they need us.

Despite the recent explosion in medical malpractice litigation, the Exchange remains in good shape financially. Much of our success can be attributed to the willingness of the company's physician directors to make tough decisions—decisions like the switch to a "claims-made" policy form...the setting of adequate premium levels...and the strengthening of standards for renewing coverage and accepting new policyholders.

In the continually changing liability climate, the Exchange's directors will continue to make the sound business decisions necessary to ensure the company's long-term financial stability. But as physicians themselves, they also will be making those decisions from a policyholder's perspective. And that will translate into the best possible insurance coverage available, including...

- ...aggressive defense of frivolous claims;
- ...policyholder participation in any decision to settle a claim or suit;

...peer review of an adverse underwriting or claim decision;

...help for policyholders in avoiding the situations that can lead to suits; and

...premium rates that fairly reflect the risks inherent to the physician's own practice.

As a company owned and operated by physicians, the Exchange exists solely for the benefit of its policyholders. Some 9,000 physicians in Illinois are depending upon us. And we don't intend to let them down.

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Ulcer therapy that won't yield, even to smoking



What do you do for duodenal ulcer patients who should stop smoking, but won't? Both cimetidine¹ and ranitidine² have been shown less effective in smokers than nonsmokers.

Choose CARAFATE® (sucralfate/Marion). Two recent studies show Carafate to be as effective in smokers as nonsmokers.^{3,4} A difference further illustrated in a 283-patient study comparing sucralfate to cimetidine⁵:

Ulcer healing rates:
(at four weeks of therapy)⁵

Sucralfate:

All patients	79.4%
Smokers	81.6%*

Cimetidine:

All patients	76.3%
Smokers	62.5%

Carafate has a unique, nonsystemic mode of action that enhances the body's own ulcer healing ability and protects the damaged mucosa from further injury.

When your ulcer patient is a smoker, prescribe the ulcer medication that won't go up in smoke: safe, nonsystemic Carafate.

Nothing works like


CARAFATE®
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Please see adjoining page for references and brief summary of prescribing information.

*Significantly greater than cimetidine smoker group ($P < .05$).

1594H7



BRIEF SUMMARY

CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate.

PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that the simultaneous administration of CARAFATE with tetracycline, phenytoin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. The clinical significance of these animal studies is yet to be defined.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No evidence of drug-related tumorigenicity was found in chronic oral toxicity studies of 24 months' duration conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies have not been conducted.

Pregnancy: Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED

CARAFATE (sucralfate) 1-gm pink tablets are supplied in bottles of 100 and in Unit Dose Identification Paks of 100. The tablets are embossed with MARION/1712. Issued 3/84

References:

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1594H7

PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

CARBONDALE:

Multi-specialty group needs the following physicians: Allergist, OB/GYN, Neurologist, Family Practitioner, Orthopedic Surgeon, V/T Surgeon, Dermatologist and Radiologist. Contact: Bill Harris, 2601 West Main, Carbondale 62901; (618) 549-5361. (12)

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C I B A

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1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically; however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS

Hyperkalemia (See OVERDOSAGE).

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients

Physicians should consider reminding the patient of the following:

To take each dose without crushing, chewing, or sucking the tablets.
To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions

Potassium-sparing diuretics, see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED

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RESOLUTIONS DEADLINE

The ISMS House of Delegates' annual meeting will convene Friday through Sunday, April 22-24, at the Westin O'Hare Hotel. Resolutions for the House of Delegates must be *received* in the ISMS offices by March 22, 1988. Those received after that date will be considered late resolutions and require special action for possible consideration.

In accord with House policy, resolutions will be published in the *Journal* by author and subject only. Resolutions received in the ISMS offices by an earlier deadline, February 19, will be published in the March *IMJ*.

1988 PHYSICIAN GAMES

Mark your calendars now for the 1988 Physician Games! The fourth ISMS Physician Games will be held Friday and Saturday, June 17-18, 1988 at the beautiful new Oakbrook Hills Resort in Oakbrook, Illinois. This year's Games will include a half-day clinical program on cholesterol; a series of individual sporting competitions in tennis, racquetball, golf and running; a resident and student team competition in basketball and volleyball; and the annual awards banquet featuring dinner, dancing and a celebrity sports speaker.

For further information watch the *Illinois Medical Journal* or contact the ISMS Division of Educational and Medical Services, 312/782-1654.

PROJECT USA SEEKS PHYSICIANS

Project USA, an AMA program, is seeking fully-licensed physicians for short-term, general medicine assignments at Indian Health Service and National Health Service Corps hospitals and clinics.

Vacancies are from two to four weeks and occur in various locations. Participating physicians receive a stipend of \$750 a week plus round trip transportation and living accommodations.

Interested physicians can contact John Naughton at the AMA, 535 N. Dearborn, Chicago, Illinois 60610; (312) 645-4702.

PHYSICIANS IN THE NEWS

Jan Fawcett, M.D., Burr Ridge, professor and chairman, department of psychiatry, Rush Medical

College and Presbyterian-St. Luke's Medical Center, Chicago, has been named to the Scientific Council of the National Alliance for Research and Schizophrenia and Depression (NARSAD). NARSAD is sponsored by the National Alliance for the Mentally Ill, the National Mental Health Association, the National Depressive and Manic Depressive Association, and the Schizophrenia Research Foundation . . . **Jere E. Freidheim, M.D.**, has been elected president of the medical and scientific staff-faculty at Mercy Hospital and Medical Center, Chicago. Dr. Freidheim is a past president of the Illinois State Medical Society and the Chicago Medical Society.

Richard J. Fantus, M.D., Chicago, has been named director of trauma services and coordinator of the surgical intensive care unit at Illinois Masonic Medical Center . . . **Ramesh C. Tripathi, M.D., Ph.D.**, Chicago, has received the 1987 Distinguished Physician's Award from the India Medical Association (Illinois) USA for promoting a greater understanding between the peoples of India and America. Dr. Tripathi is professor of ophthalmology and visual science at the University of Chicago, and is affiliated with the University of Chicago Medical Center and Oak Forest Hospital . . . **Joel Shalowitz, M.D., M.M.**, Glencoe, has been named director of the program in hospital and health services management at Northwestern University's Kellogg Graduate School of Management. A board certified internist in private practice in Skokie, Dr. Shalowitz is affiliated with Evanston Hospital, Rush North Shore Medical Center, Northwestern Memorial Hospital and Saint Francis Hospital, Evanston.

Donald W. Aaronson, M.D., Chicago, has been chosen president-elect of the American College of Allergists, at its 44th Annual Congress in November. Dr. Aaronson, a board certified allergist and immunologist, is president of the medical staff at Lutheran General Hospital, Park Ridge . . . Chicago College of Osteopathic Medicine (CCOM) has named **George Caleel, D.O.**, Chicago, a recipient of a Distinguished Service Award for his advancement of osteopathic medicine, service to mankind and support of CCOM. Dr. Caleel is director of endocrinology and nuclear medicine and professor of medicine at the college. ◀

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Splenic Abscess

By NESTOR S. CUASAY, M.D., TARA TALWAR, M.D.,
AND HULYA LEVENDOGLU, M.D./CHICAGO

Splenic abscesses are rarely encountered in clinical practice and often go unrecognized or are discovered incidentally. Twenty-one percent of splenic abscesses were diagnosed only at autopsy.¹ Autopsy incidence has been placed at 0.14%-0.7%,¹ with a mortality of 60%-100%. This case report describes the clinical presentation and management of a patient with a splenic abscess and three liver abscesses. Each liver abscess was drained percutaneously, and a splenectomy was performed for treatment of the splenic abscess.

While percutaneous drainage of pyogenic liver abscesses is a generally accepted procedure, this is not the case with splenic abscesses. This article reviews the literature on splenic abscesses, defines the criteria and describes the advantage of percutaneous drainage.

A 48-year-old black male was admitted with a six-week history of right upper quadrant pain and fever. The patient had been hospitalized three weeks prior for chest and right upper quadrant pain. Cardiac enzymes and a technetium pyrophosphate myocardial scan confirmed the presence of a subendocardial myocardial infarct. One week prior to the present admission, the patient was evaluated in the emergency room for shortness of breath, and was found to be hypoxic with scattered rales on auscultation. Chest x-ray showed bibasal plate-like atelectasis. He was treated with erythromycin, but worsening of symptoms prompted the present admission. The patient appeared toxic and was in mild respiratory distress. He was febrile, with a temperature of 101.7°F; his pulse rate was 116/min and respiratory rate was 28/min. Scattered rales were heard on auscultation

and there were no cardiac murmurs. The liver was palpable 4cm below the costal margin and the splenic tip was just palpable, but non-tender. Serum albumin was 2.6gm/dl with a reversal of the albumin globulin ratio. Serum alkaline phosphates were elevated at 194U (normal 115), WBC count was 22,500 with 88% polymorphonuclear cells. Serial blood and urine cultures were negative. Chest x-ray showed bibasal plate-like atelectasis, without elevation of the diaphragm. Abdominal radiographs were unremarkable.

Ultrasound examination of the right upper quadrant revealed a 9 × 10cm complex septated mass in the right lobe of the liver. Computed tomography of the abdomen revealed a similar multiloculated mass. Under CT guidance, using a 9.5 French size Sacks catheter, more than 350ml of purulent material was drained from the largest cavity.

Contrast material injected after drainage proved that the other two cavities were separate. (Figure 1) These were then drained and 35ml and 15ml, respectively, were aspirated from each. Cultures grew *Bacteroides oralis* and *Bacteroides fragilis*. Computed tomography also revealed a 4cm radiolucent nonenhancing mass in the spleen, an area not examined by ultrasound. Percutaneous drainage was deferred as gastroenterology and surgery consults unanimously favored surgery. When the patient did not defervesce three days following percuta-



Figure 1
CT examination shows three abscess cavities in the right lobe of the liver. Contrast material injected into the largest cavity shows non-communication with the two more-posteriorly situated abscess cavities which were each independently drained. A 4cm-radiolucent defect is identified in the spleen.

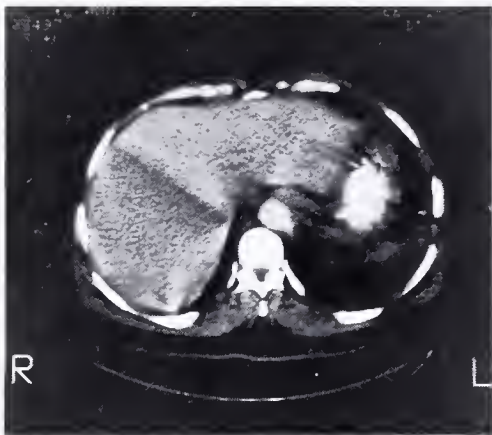


Figure 2
A repeat CT examination 18 days after splenectomy shows the liver abscesses have resolved.

neous drainage of the liver abscesses, a splenectomy was performed. The spleen weighed 146gms and a central defect was seen on cut section. Microscopic examination revealed a dense infiltration with acute and chronic inflammatory cells. Areas of hemorrhage were seen, in addition to gram positive and gram negative bacteria.

The patient recovered uneventfully and was discharged 22 days after surgery. A repeat CT scan 18 days after splenectomy showed a well-regenerated liver with no evidence of abscess. (Figure 2) Retrospectively, the history of a shoulder abscess drained four weeks prior to this hospitalization was obtained.

Discussion

This case of a splenic abscess with concomitant liver abscesses illustrates that while percutaneous drainage of liver abscesses has been widely accepted, this has not been true with the rarer splenic abscess.^{2,3} Percutaneous drainage of splenic abscesses has been described in the literature since 1980, with 14 cases reported at this writing. (Table I) It was shown that solitary abscesses had an excellent response, while multiple abscesses had a lower success rate.

This presentation typifies the reluctance of the clinician to try the less invasive, but perhaps equally efficacious, percutaneous approach in draining splenic abscesses.⁴ Inexperience, limited success rates (blamed on multiloculated ab-

Table I:
Splenic Abscesses Percutaneously Drained
A Partial Review of the Literature

Author's Name	Solitary Abscess	Multiple Abscess	Total #	Surgery	Death
(Successful/Total Number Drained)					
Moss—1980 ¹⁰	1/1	0	1	0	0
Beckman—1983 ⁵	1/1	0	1	0	0
Gerzoff—1985 ³	3/5	0/3	8	5	?
Lerner—1984 ⁶	2/2	0	2	0	0
Kreel—1985 ¹¹	1/1	0	1	0	0
Wernecke—1985 ⁹	1/1	0	1	0	0

scesses), the use of small catheters and the fear of inducing bleeding have all contributed to the lukewarm response to this therapeutic modality.^{3,5}

Traditional measures mandate surgical management, namely a splenectomy, as the mainstay of treatment.^{2,4} This patient had an uneventful course following a sple-

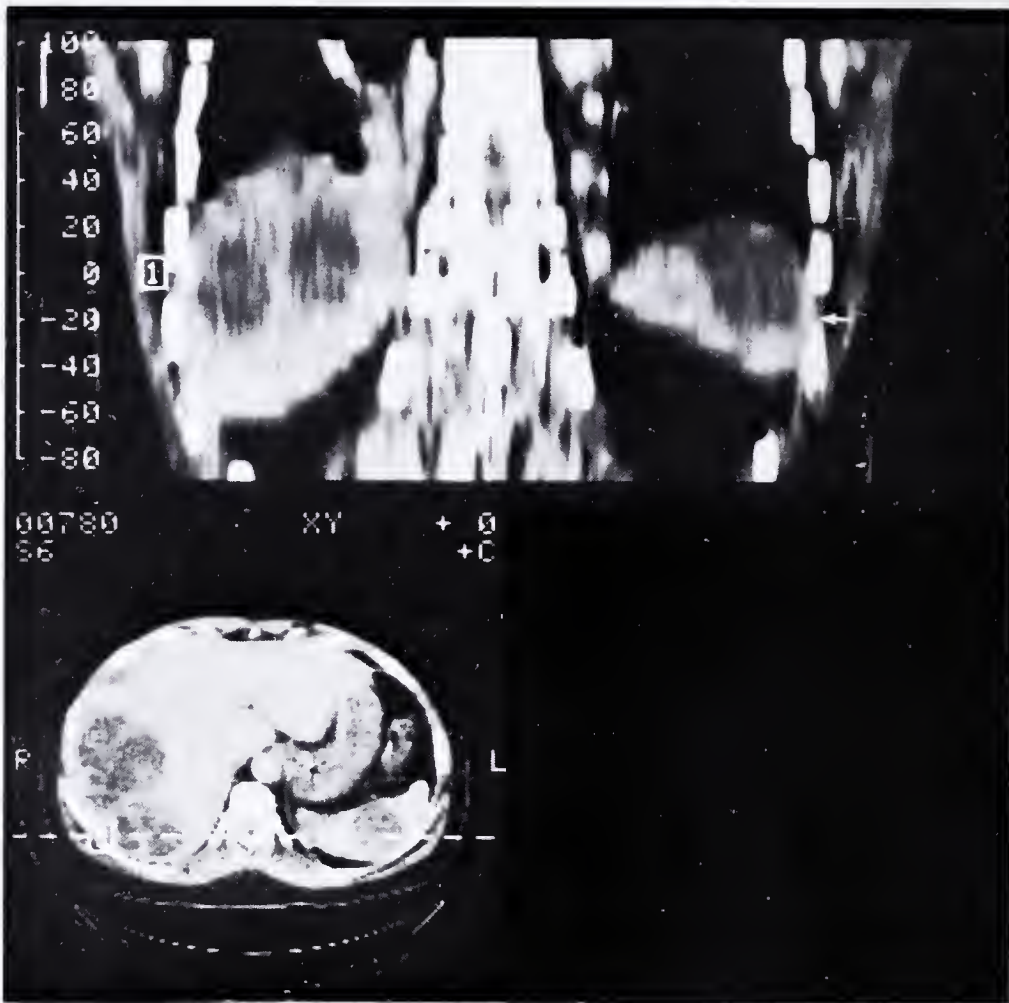


Figure 3
Coronal reconstruction of the upper abdominal CT shows the liver abscesses before drainage. The reconstructed image shows to better advantage a safe access route for percutaneous drainage of the splenic abscess (arrow) just above a rib and below the pleural reflection.

nectomy despite a recent subendocardial myocardial infarct. The splenic abscess was unilocular, without a splenic rind to be traversed by the draining catheter, and had a safe access route free of intervening bowel or pleura. (Figure 3) In retrospect, the abscess met all criteria for percutaneous drainage, and in view of the clinical setting, would have offered a lower morbidity.^{5,6} The risks of overwhelming post-splenectomy infections have been highlighted in recent years. In addition to a shorter hospitalization, percutaneous drainage preserves splenic tissue. Splenectomy should be reserved for percutaneous drainage failures, which appear to be higher with multiloculated abscesses than with solitary splenic abscesses.³

When a solitary splenic abscess with a safe access route is identified, an attempt should be made to drain it percutaneously. Because the ultrasound examination of this patient did not include the spleen, the lesion was not detected. Ultrasound examinations have anatomic and physiologic limitations and results may vary according to the skill of the operator and interpreter.^{7,8} Computed tomography can be a better guide than ultrasound in the detection of abscesses and in mapping an ideal route for drainage.^{5,6,9}

Patients at high risk for developing splenic abscesses include those with subacute bacterial endocarditis, diabetes mellitus, trauma, intravenous drug abuse, hemoglobinopathies, skin sepsis and urinary or upper respiratory tract sepsis.¹ This patient did not meet any of these

criteria and, except for the history of a shoulder abscess, no other predisposing factor could be identified. A detailed gastrointestinal work-up after discharge did not contribute any further information. A high index of suspicion is mandatory in the detection of this elusive, but fortunately, rare disease. A careful evaluation of each case with close communication between the interventional radiologist and the surgeon should be undertaken to allow for the most beneficial decision. ◀

Acknowledgement

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Hemorrhagic Metastatic Melanoma

BY MOHAMMAD NASEEM, M.D., RAMAKRISHNA DEVASTHALI, M.D.,
MOHAMMAD SARWAR, M.D./CHICAGO

Malignant melanoma is the third most frequent metastatic disease in the central nervous system.^{1,2} Many studies have shown that cerebral metastases from malignant melanoma are frequently hemorrhagic.¹⁻⁴ Non-neoplastic multiple intracerebral hematomas are rare,⁵ but manifold lesions usually suggest metastatic tumor. The following is reported for its somewhat atypical presentation, resulting in delayed diagnosis.

J.B., a 27-year-old-male, was seen in our institution's emergency room following blunt head trauma. Four weeks prior to admission, the patient had been treated for trauma at another hospital. Physical exam and initial labs were unremarkable. Noncontrast and contrast CT scans of the head at that time showed hemorrhagic lesions in the right frontal and temporal lobes, (Figure 1A) and left cerebellar hemisphere. (Figure 1B). Enhancement of the left cerebellar lesions were questionable. In view of the history of trauma, emergency surgical drainage of the right temporal lobe and left cerebellar lesions was performed. No biopsy was taken and pathological specimen was interpreted as blood clot. A postoperative bilateral carotid arteriogram revealed an abnormal area of vascularity in the left cerebellar hemisphere with an early draining vein. This was interpreted as neoplastic vascularity. A noncontrast postoperative CT scan was unremarkable. The patient was discharged after an unremarkable postoperative recovery.

One month later the patient was readmitted with complaints of nausea, vomiting, frontal headaches and anorexia. A plain CT scan at

this time again showed hemorrhagic lesions in the right temporal and left cerebellar areas, but right frontal lobe hemorrhage was resolved. (Figure 2) The patient denied having had recurrent trauma prior to this admission. A left occipital craniotomy was performed and a biopsy of the cerebellar lesion was taken. This was initially reported as poorly-differentiated melanotic cells. A search for the primary tumor was



Figure 1A (left) and B (above)
Noncontrast CT scans demonstrate hematomas in the right frontal lobe (A) and left cerebellar hemisphere (B).

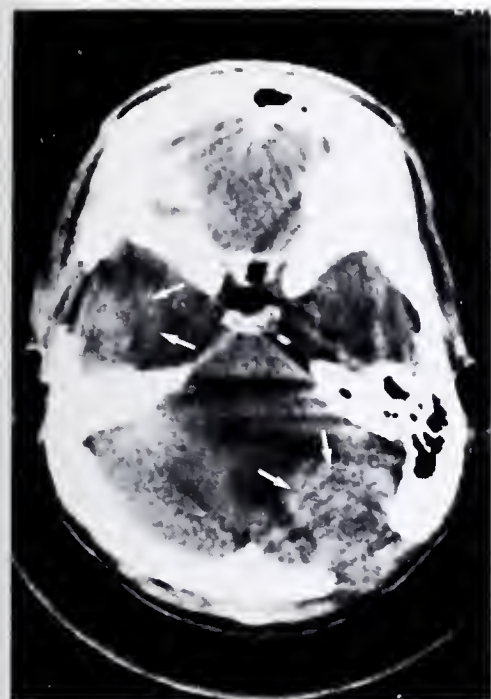


Figure 2
Noncontrast CT scan depicts recurrence of bleeding in the left cerebellar hemisphere and right temporal lobe lesions (arrows).

unsuccessful and no other metastatic deposits were found.

Discussion

Eighteen percent of cerebral neoplasms are metastases. Of these, 5%-10% are from melanoma.³ In order of frequency, tumors most inclined to develop such hemorrhages are: metastatic choriocarcinoma, melanoma, bronchogenic carcinoma and hypernephroma.^{6,7}

Hemorrhage has been observed in a variety of primary and secondary neoplasms. In one series, six out of eight tumors with massive bleeding were metastatic in origin, and four out of these six were hemorrhagic metastatic disease.⁶ The underlying pathology included choriocarcinoma (three cases), bronchogenic carcinoma (eight cases), and one case each of hypernephro-

ma, laryngeal epidermoid carcinoma, embryonal carcinoma of the testicle and carcinoid tumor.

Our patient presented with a definite history of trauma, and prior history of head injury, which had been treated (methods unknown) at another institution. CT examination was convincing, but clinical presentation was deceptive and led to the assumption of posttraumatic intracranial hemorrhage. Therefore, no attention was given to obtaining multiple biopsies from the margins of the lesions at the time of the first surgical exploration.

Conclusion

Metastatic disease may present initially as intracerebral hematoma. In our case, although CT aroused a suspicion of metastatic disease, the clinical picture was atypical, leading to differing opinions and causing delay in diagnosis. Clinicians should be aware of atypical clinical presentation of metastatic disease, which should be considered a possibility whenever the bleeding site is unusual and clinical picture is doubtful.

If emergency evacuation of the hematoma is contemplated, multiple biopsies should be obtained at the margins of the lesion and all contents should be evaluated pathologically. ◀

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Anuria Caused by Renal Artery Stenosis

By MARK A. RAUTER, M.D., F.A.C.S./ROCKFORD

A case of reversible acute anuria secondary to renal artery stenosis associated with contralateral renal artery occlusion is presented. The literature is reviewed relative to acute anuria on the basis of renal artery occlusion or stenosis. The latter is a relatively infrequent cause of this problem. The role of blood pressure reduction as a precipitating factor is emphasized.

Renovascular disease is well known as a cause of hypertension, and is also recognized as a cause of renal failure. These conditions may occur with occlusion or critical stenosis of the renal artery, and renal failure may become clinically manifest in the presence of bilateral renal artery disease, or with unilateral involvement of the artery to a solitary functioning kidney. Acute anuria has been reported in this setting, most commonly due to complete renal artery occlusion. The cause of this occlusion may be either embolic or thrombotic. Less commonly reported is anuria secondary to renal artery stenosis. The following report documents such a case, which was successfully reversed with aorto-renal bypass grafting.

Case Report

A 79-year-old woman presented to the emergency room with a four day history of abdominal pain, nausea and emesis. Her history included a diagnosis of hypertension, and heavy cigarette smoking. On examination, she was afebrile. Blood pres-

sure was 250/134. A systolic ejection murmur was noted. Her abdomen was tender in all quadrants. No bruits were noted. Pedal pulses were not palpable. Admission laboratory data included: hematocrit 46, hemoglobin 15, WBC 10,100, BUN 42, creatinine 6.8, sodium 136, potassium 5.1, glucose 223, amylase 55. Her presentation was felt to be consistent with cholecystitis, as well as severe hypertension.

She was admitted to the intensive care unit and treated with nitroprusside, hydralazine, and nifedipine, resulting in a decrease in blood pressure to 160/100. Although initially alert, she became obtunded, and then comatose. Next she became anuric, and received furosemide, mannitol, and further intravenous hydration without improvement. After two days, the patient remained anuric. Her BUN had increased to 68, and serum creatinine to 9.6.

An ultrasound scan revealed an 11-centimeter right kidney, and an 8-centimeter left kidney. A renogram revealed little uptake by the right kidney, and none by the left.

An arteriogram demonstrated a high grade stenosis at the orifice of the right renal artery, with complete occlusion of the left renal artery.

Following completion of these studies, the patient underwent hemodialysis, and subsequently an aorto-right renal artery bypass was constructed, using a saphenous vein graft. No thrombus was found in the renal artery. A cholecystectomy was done concomitantly for calculous cholecystitis. Within several hours of the procedure, urine output returned. Initially this was scant, but the volume steadily increased. Blood pressure was maintained in the normal range, initially with the aid of intravenous nitroglycerine. She was dialyzed once postoperatively.

By the twelfth day her BUN was 26 and creatinine was 1.8. Her mental status also was markedly improved. She was discharged on the thirteenth postoperative day, with urine volume in the normal range and satisfactory blood pressure control on oral medications.

Discussion

Renal viability may be maintained by a perfusion pressure below that which is necessary for the formation of urine, as was demonstrated in dogs in 1955.¹ Subsequent reports have confirmed the clinical relevance of this phenomenon. In 1962, a series of eight patients with renovascular hyper-

tension and azotemia was published.² Each of these patients had either bilateral renal artery stenosis, or unilateral stenosis in the absence of a contralateral kidney. Following unilateral revascularization the majority had control of hypertension, and, significantly, all were noted to have improved renal function. Thus, the reversibility of chronic renal failure due to renovascular disease was documented.

In 1965, a report appeared of a patient with atherosclerotic narrowing of the renal artery, four years after removal of the contralateral kidney for hypertension.³ Recurrent hypertension had developed, and subsequently, the stenosis had been documented to progress to thrombosis with anuria. A reconstructive procedure successfully reversed this problem, demonstrating that anuria was not proof of irreversible kidney damage. This was felt to be due to maintenance of renal viability from collateral circulation. Further reports of similarly reversible anuria appeared, typically in the setting of renal artery thrombosis superimposed upon previous contralateral nephrectomy.⁴⁻⁶

Additional experience was obtained by a 1982 report of six patients with renal artery occlusion and anuria.⁷ All had restoration of renal function by revascularization. Emphasis was placed on the concept of pre-existing stenosis as a stimulant of collateral formation sufficient to maintain viability. Assessment of patients with anuria of acute onset by isotope scanning and arteriography was recommended, in order to detect proximal renal artery disease in preparation for revascularization.

A review of renal artery disease published in 1985⁸ discussed the spectrum of impairment that may be seen with renal artery occlusion. This ranges from hypertension with impaired renal function, to hypertension without renal function, to total loss of viability without either hypertension or function. Therefore, renal function after occlusion is never normal, but the degree of impairment is variable, depending on the status of the collateral circulation. The clinical presentation will then be based upon this, as well as

the condition of the contralateral kidney. The authors also point out that if clinical improvement in renal function is to be achieved, there must be evidence of a concomitant increase in renin secretion. That is, if there is no hypertension, no functional improvement can be expected.

Acute anuria due to renal artery stenosis, as opposed to occlusion, has been much less frequently noted, and forms the basis for the present report. The above discussion of pathophysiology also pertains to such patients. Of course, viability may be maintained in part by flow through the stenotic vessel, as well as from the collateral bed.

Two patients with acute anuria caused by renal artery stenosis were reported in 1976.⁹ As the authors of that paper discuss, approximately a 70% reduction in luminal diameter is thought to be necessary to significantly decrease organ perfusion. A moderate diminution in flow may cause hypertension with minimal functional change, while a further decrease may cause functional loss as well. This may be initially reversible, and later progress to irreversibility. Thus, a narrow spectrum of anatomic progression may be associated with a wide spectrum of functional distortion.

A 1985 report also documents two patients with anuria associated with stenosis.¹⁰ According to these authors, this rare event occurs in atheromatous patients with severe hypertension, in whom the onset of anuria follows a fall in blood pressure. Relevant to this, the patient in the present report was presumably dehydrated at the time of her admission, due to an ongoing episode of cholecystitis. When control of her severe hypertension was achieved, anuria promptly ensued.

If stenosis is demonstrated in the artery to a solitary functional kidney, revascularization should be considered before dysfunction occurs. This may avoid loss of significant renal mass, and a potentially overwhelming threat to life. However, experience has demonstrated that revascularization should still be performed in cases where function has been lost, similar to this patient, as long as there is evidence of viability.

This may be the case even after a significant delay, and coexisting renovascular hypertension is helpful in making this determination.

Acknowledgement

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THE VIEWBOX

CONTRIBUTING EDITOR TERRENCE C. DEMOS, M.D., PROFESSOR OF RADIOLOGY, DEPARTMENT OF RADIOLOGY, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

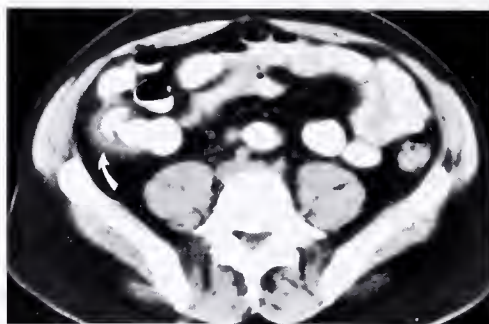
This month's Viewbox was contributed by Paul W. Finnegan, M.D., C.M., department of radiology, Loyola University Medical Center, Maywood.

This 38-year-old man with leukemia (AML), currently receiving chemotherapy, developed right lower quadrant abdominal pain and blood in stool. He has right lower quadrant tenderness. In addition, a mass was palpated in the same area.

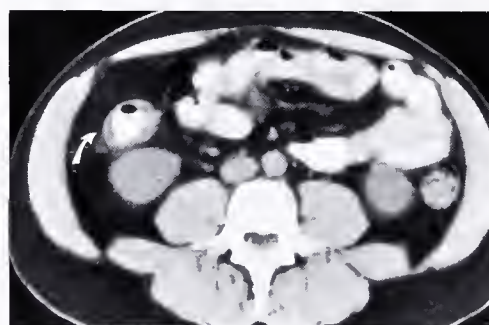


Figure 1
Supine view of the abdomen. There is thickening of the wall of the ascending colon (arrow).

Figure 2
Abdominal CT.



(A) *The cecal wall is thickened (arrow).*



(B) *The wall of the ascending colon is thickened (arrow).*

Your diagnosis?

1. Periappendiceal abscess
2. Intramural hemorrhage of the cecum
3. Neutropenic typhlitis
4. Ogilvie's syndrome involving the cecum
5. Pneumatosis intestinalis of the cecum

(continued on page 52)

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Brief Summary

Professional Use Information

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CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

- Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
- Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
- Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
- Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies,

oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes, however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility.

A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in *in vitro* bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryonic and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women, therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%).

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Cardiovascular:	Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope
Nervous System:	Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor
Gastrointestinal:	Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase
Dermatologic:	Petechiae, pruritus, photosensitivity, urticaria
Other:	Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

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SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies. This information was gathered through correspondence or by ISMS representatives and staff who attend meetings on behalf of Illinois physicians.

From the Department of Public Health (IDPH)

Incidence of AIDS in Illinois

The overall incidence of reported AIDS cases in Illinois increased by 11 percent between September 30 and November 30. This increase is a result of the application of a new CDC case definition to cases previously reported to IDPH.

The new case revisions were made in order to simplify the definition and to become more consistent with current diagnostic practices. The new revision includes the reporting of individuals with HIV wasting syndrome (ARC) and HIV encephalopathy (dementia complex). Additional opportunistic infections have been added to the list of indicator illnesses.

Patients who have taken immunosuppressive medications and have been diagnosed with an indicator illness will also be counted as cases, provided there is supporting lab evidence of HIV infection. Under the old case definition, these individuals were not included. Methods of diagnosis have been expanded to include not only the definitive methods, but presumptive diagnosis of several indicator illnesses as well.

Forty previously submitted cases were reviewed and met the new CDC case definition. Fifty-three new cases were submitted during the month of October, and 42 in November.

As of November 30, 1987:

Total cases of AIDS in Illinois: 1,371

Males: 1,312, females: 59

Chicago residents: 985

Chicago metropolitan: 1,230

Downstate Illinois: 141

Counties with 10 or more cases: Cook-1,133, DuPage-32, Lake-27, Kane-23, Will-15, St. Clair-15, Champaign-13, Sangamon-12, Madison-11, Winnebago-11.

(Source: IDPH AIDS Surveillance Coordinator)

HIV Testing for Marriage License Applicants

Under a new Illinois law effective January 1, 1988, within 30 days of requesting a marriage license, couples must obtain a certificate from a physician which states they have been tested for the presence of HIV infection and have received the results of such tests.

Each party tested may request his or her physician to label the sample so as to preserve confidentiality. Couples may be examined and tested by separate physicians, but each physician must report the test

results to both parties. A negative result need not be communicated to the parties in person.

If a test has been confirmed positive, the physician is required, before issuing the certificate, to give notice of the positive result, in person, to both parties of the proposed marriage. The physician must also provide the couple with information regarding the meaning of a positive result, and the availability of further testing and counseling, as appropriate.

The law requires physicians to report confirmed positive results of HIV tests to the local health authority or IDPH. The rules developed to implement this law will require that results of positive tests include only the patient's sex, age, race or ethnicity, risk factors (*e.g.*, homosexual male, IV drug user) and the physician's name and address. Reporting can be done by mail or phone. The physician is to maintain the confidentiality of the test results in all other cases.

The certificate signed by the physician and given to the county clerk does not include test results. It only confirms that the test has been performed and the parties have been notified of the results.

A brochure describing the testing requirements of the Illinois Marriage Act will be sent to all physicians. This brochure, which can be used in counseling the patient, can be ordered in quantity from IDPH or county clerks and distributed to interested patients.

(Source: Letter to physicians from the Director of IDPH)

HIV Testing for Insurance Purposes

Another new Illinois law deals with HIV testing for those who apply for insurance. Under this law, physicians who perform insurance physicals should note that HMOs, insurance companies, fraternal benefit societies and other insurers which require that an insured patient or applicant for new or continued insurance be tested for HIV infection must: (1) give the patient/applicant prior written notice of such requirement; (2) obtain a written authorization of the patient/applicant to proceed with the testing, and (3) keep the results confidential.

While notice of an adverse underwriting decision may be given to any interested party, the insurer may only disclose the HIV test result to a physician designated by the patient/applicant. Any such disclosure must be made in a manner which assures confidentiality.

(Source: Sec. 20.1 of the AIDS Confidentiality Act)

HIV Pre-Test Information

A third new HIV testing law deals with the information

and process required to perform an HIV test in situations *not involving* marriage licenses, insurance physicals, organ donations or research (where the identity of patient is not known).

This law states that a physician who orders an HIV test must make available to the patient the following information *prior* to performing the test: (1) a description of the meaning of the test results (such as purpose, potential use and limitations of the test and results); (2) availability of additional confirmatory tests and (3) availability of referrals for further information or counseling if appropriate.

The physician must obtain a written, informed consent from the patient or the patient's legally authorized representative. The consent is to be kept in the patient's medical record. IDPH has created a model form for use in physician offices.

Any patient who undergoes an HIV test has the right to request anonymity, and to provide consent using a coded system that does not reveal the patient's identity with the test result. In this way only the physician knows whose blood was tested and can insure that the results are given to the correct patient.

Under this law, patient's identity or the test results *may be disclosed* to the following persons:

1. The subject of the test or the subject's legally authorized representative.
 2. Any person designated in a legally effective release of the test results, executed by the patient.
 3. An authorized agent or employee of the physician or hospital, if the agent or employee provides patient care or handles or processes specimens of body fluids or tissues, and if the agent or employee has a need to know such information; this will include treating, referring and consulting physicians.
 4. IDPH, in accordance with rules on reporting.
 5. A health facility or provider which may procure, process, distribute or use a human body part from a deceased person for medical information on the patient, or semen for artificial insemination.
 6. Hospital committees which monitor programs or services.
 7. A person who has access by a court order.
- (Source: *AIDS Confidentiality Act*)

From the Department of Professional Regulation

New Name For the Department

Starting January 1, 1988, the Department of Registration and Education will be renamed the "Department of Professional Regulation (DPR)." This change was made to more accurately reflect the activities of the agency. ◀

YOCON®

YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

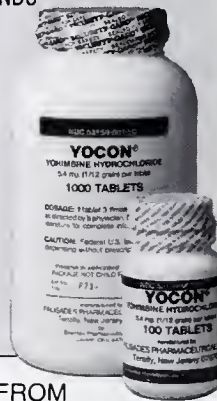
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Chronic dislocations in the shoulder are a significant factor in constant pain and disability cases. When the humeral head shows minimal damage only, open reductions may give satisfactory results. When the humeral head shows severe damage, a prosthetic replacement is suggested. Each of seven patients with chronic dislocations had a prosthetic replacement with a postoperative sling and swathe and early mobilization. No patient experienced a redislocation; five patients had good results and two patients had fair results. (Pritchett, J., Clark, J., *Clin Orth and Related Research* 216:89-93, 1987.)

The Ontario Child Health Study surveyed 3,294 children between 4-16 years of age in a general community for psychiatric and social adjustment problems among children. Those with and without chronic illness and long term disability were compared. It was found that children with both chronic illness and associated disability were at greater than threefold risk for psychiatric disorders and showed greater risk for social adjustment problems. Children with chronic medical problems but without a disability had a twofold increased risk for psychiatric disorders but no significant risk for social adjustment problems. The authors suggest a high index of suspicion by primary physicians in the psychiatric evaluations of these children. (Cadman, D., *et al.: Pediatrics* 79:805-813, 1987.)

Adjusted subcutaneous heparin calcium may be an effective and safe alternative to continuous intravenous heparin calcium in the initial treatment of acute proximal deep vein thrombosis. Pulmonary embolism risks were noted in 51% of patients with proximal vein thrombosis and in 33% of patients with calf vein thrombosis. Heparin doses were adjusted and based on the activated partial thromboplastin time. Fifty-one patients received the subcutaneous heparin while 52 received the intravenous heparin. (Doyle, D., *et al.: Ann Int Med* 107:4, 441-45, 1987.)

Acute confusional state and acute agitated delirium are common syndromes after infarction of the middle cerebral artery. Twenty-five of 41 patients had acute confusional status when tested within three days of stroke onset. Recovery was good except for five patients who continued to present at time of discharge, three or more months later. Nineteen (76%) of these 25 cases had their occlusion in the right middle cerebral artery. The acute confusional state correlated highly

with damage to the basal ganglia and inferior frontal gyrus. Six patients (15%) exhibited acute agitated delirium. Their lesions were located in the middle and posterior temporal artery branches of the middle cerebral artery, with infarction of the middle temporal gyrus. (Mori, E., Yamadori, A.: *Arch Neurol* 44:11, 1139-43, 1987.)

Cortical irregularities of the distal femur in children and adolescents can be easily mistaken for a malignant process. These processes have been referred to in several ways, including periosteal desmoid, subperiosteal abrasion, cortical abrasion and medial distal metaphyseal femoral irregularity, but avulsive cortical irregularity seems the most appropriate. In most cases the lesion is an asymptomatic incidental finding commonly seen in children between the ages of 10-15 years, and predominantly in males, with an incidence of 11.5%, compared to 3.6% of females. The lesion is characteristically located along the posterior medial aspect of the distal femoral metaphysis at the insertion of the adductor magnus muscle. During rapid growth, remodeling and mechanical stress of the adductors, microavulsions of the cortical bone elicit a hypervascular and fibroplastic response with increased osteoblastic response. If the x-rays are not in the characteristic location and pain is present, biopsy may be indicated. (Bernasek, T., *et al.: Orthopedics* 10:10, 1423-5, 1987.)

Discitis is reported to occur in children less than five years of age, and is seen after the patient had a viral infection presenting with symptoms of irritability, poor localized back or abdominal pain, and refusal to sit, stand or walk. On examination there may be paraspinal muscle spasm in the lumbar or thoracic areas, positive straight leg raising, abdominal or flank tenderness and gait abnormalities. The sedimentation rate and white blood counts are elevated. Initial management should include a TB test, sickle cell screen if indicated, blood urine and throat cultures. Disc space narrowing may not be present until three weeks later, thus a bone scan would be more useful, especially 3-5 days after onset. Bone scan classically reveals an increased tracer uptake at adjacent end plates contrasted to other conditions that may involve only one end-plate. If a follow-up scan is negative, another diagnosis should be considered. Bed rest and, occasionally, a cast may be required. Non-steroidal anti-inflammatory agents are useful adjuvants. (Lopez, E., Dvonch, V. *Orthopedics* 10:10, 1476-8, 1987.)

BOT Abstracts

(Continued from page 11)

OTHER ACTIONS

In addressing various other issues, the Board:

- Accepted the September 30, 1987, Financial Statements; September 30, 1987, IMPAC Collection Data; September 30, 1987, Dues Payment Report. Requests for Changes in Membership Status were approved.
- Reported that the recently-formed Board of the Insurance Trust administering sponsored insurance programs, chose "Physicians' Benefit Trust" as the name for the trust, and elected Dr. Arthur Peterson, Chicago, its chairman.
- Agreed to a moratorium on acceptance of manuscripts for *IMJ* editorial review. The moratorium will be in effect until the Board has learned the results of the communications study and will be terminated at the discretion of the Publications Committee. An announcement will be published in the *IMJ*.
- Approved a Health Screening Fair for members of the General Assembly, their executive staff, directors and assistant directors of various agencies. An amount of \$10,000 is included in the 1988 budget for legislative activities. The Board of Trustees will be informed of definite plans at the next Board meeting.
- Adopted positions recommended by the Governmental Affairs Council on a list of primary bills pending in the 85th General Assembly.
- Agreed to introduce legislation requiring the Illinois Department of Public Health to develop a brochure that would include current recommendations for the screening and early detection of breast cancer, such brochures to be distributed through physicians' offices if they so choose and through other appropriate methods of distribution.
- Nominated Arthur R. Traugott, M.D., as a candidate to serve on the AMA Council on Medical Services.
- Agreed to co-sponsor an AMA Resolution on Cost Cutting at AMA Meetings, with New York, New Jersey, California, Florida, Pennsylvania and Texas.

PROGRAMS

The Board approved:

- Conducting a clinical sports medicine program at the 1988 Prairie State Games for all volunteer health and medical staffs. Expenses for this program have been built into the 1988 budget, however, there is a good chance of getting corporate sponsorship for the event.
- Sponsorship of a Midwestern Leadership Confer-

ence for medical student leaders and representatives on March 6, 1988, at the ISMS headquarters office. Expenses would be minimal and within the regular ISMS-MSS budget.

NOMINATIONS

- Ratified the nominations of Drs. Thomas Minogue, Champaign, chairman of the ISMS Council on Mental Health and Addiction, and Hazel Mrazek, Riverside, president of the Illinois Psychiatric Society, to serve on the Governor's Commission to Study the Mental Health Code.

POLICIES/POSITIONS

Various official ISMS actions and policy manual statements were reported to the Board by councils and committees based upon their review of 5-year-old policies. The Board approved modifications of policy and position statements on the basis of these reviews. Changes will be reflected in the book of official ISMS actions and the 1988 policy manual.

INFORMATIONAL REPORTS

The Board heard the following informational reports:

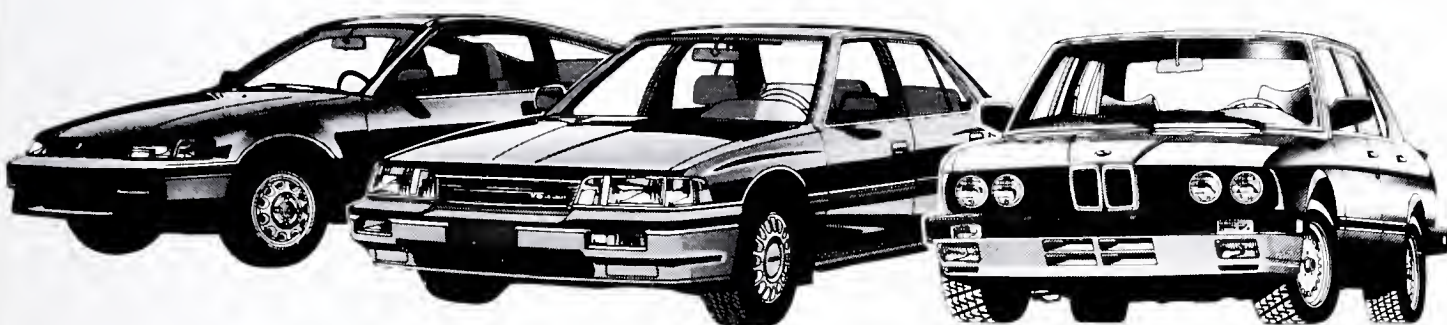
- (A) The Health Care Financing Administration (HCFA) recently announced a 38.5% increase for Medicare Part B premiums. As a result, several negative reports were developed in the media which impacted on physician fees. The AMA has objected and asked for information as to the specific reasons for the increase. The Society has taken this opportunity of commenting to HCFA and urging that they answer the AMA questions so that physicians may determine what portion of the increase is in fact attributed to factors other than physician fee raises.
- (B) Alfred J. Clementi, M.D., past chairman of the ISMS Board of Trustees, gave an informational update on tort reform. Dr. Clementi is a member of the AMA Special Task Force on Professional Liability that is studying a fault based administrative system—an alternative to the civil justice system. The Task Force will report at the next AMA House of Delegates Meeting.
- (C) Council on Economics, ISMIS, ISMIE, Auxiliary, IMPAC, Trustees, Speaker of the House and Executive Administrator.

NEXT MEETING

The next Board meeting was set for January 30, 1988, at ISMS Headquarters.

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Working Toward a Drug-Free America

By LYNN KASSEL (Mrs. WAYNE), ISMSA PRESIDENT

The year is 1970 . . . Our family relocated to this town, where my husband will be practicing medicine. I joined the medical auxiliary and the emphasis this year is on drug education. The medical society and the auxiliary joined forces to fight against this blight on middle class America by forming a speakers' bureau that would inform the community. Our children are very young. *Marijuana* is thought to be harmless, safer than alcohol. . . .

The year is 1980 . . . I am president of the county medical auxiliary. Some of our children are now in high school. Our family is about to embark on a three-year fight against drugs, during which time I will learn more about the subject than I want to know. In fact, we are up to our knees in information, but it appears the war against drugs is being lost. We will win the battle for our daughter, but not without scars. No one can tell us that marijuana is harmless. In fact, researchers have discovered that brain cells can be permanently damaged by the THC in "pot." *Cocaine* is the new "non-addictive" drug used for recreation, a harmless substance. . . .

The year is 1988 . . . I am president of the Illinois State Medical Society Auxiliary and I know of many families in my peer group still battling the horrible effects of drugs on their children, themselves, their communities. Cocaine is now known to be addictive, and researchers have found that laboratory mice will repeatedly choose cocaine to the exclusion of all else

against drugs. The Reagans' campaign of "Just Say No" is now embracing every level of society in an attempt to stem the demand for drugs and, thus, dry up the supply.

Over the last twenty years information on drugs has increased, along with budgets to implement programs. But no obvious dent in drug-traders' profits has appeared.

. . . (R)esearchers have discovered that brain cells can be permanently damaged by the THC in "pot."

until death takes over. It is two years before the next decade and we are surrounded by information about drugs. Have we lost the war? . . .

The White House Conference on Drug-Free America offers new hope to the nation in its battle

This conference merges experienced people in all walks of life and asks them for help in designing a program that will encourage new generations to say "NO" to drugs. The lines of territory and turf will be crossed, with everyone working for the same cause. Six regional

conferences have gathered national sources together in 10 separate committees this past fall. The abstracts from these committees will be brought to Washington, D.C. in March, where leaders from communities across the nation will meet to design the program.

An example of what is already in place is evident in the advertising arena. Four agencies have joined with the media to wage war against what many believe to be the nation's number one socioeconomic problem. Annually, \$11 billion is spent on illegal drugs. Over the next three years, \$500 million will be donated by these corporations to reinforce the positives of a life without drugs. Look for ads on televi-

sion and radio, and in magazines and newspapers. They will focus on cocaine, "crack" and marijuana, and will be aimed at three levels of consumers, those aged 6-11, 12-17, and 18-32.

This campaign promises to be exciting and productive. As one of the few volunteer groups asked to join the initial proceedings through the AMAA, ISMS auxiliary is already making plans to be involved. We need to reach into every community.

The year is 2000 . . . Our family is grown now with families of their own. The grandchildren write us of their school classes and their community involvement. We don't read much about drugs anymore, except

for those that make headlines because of miracle cures. I guess my generation's efforts to eliminate drugs paid off. Countries no longer can claim cocaine and marijuana as their main cash crop. Our strict drunk-driving laws weren't too popular in the beginning with those who lost licenses and had their cars impounded, but now even those people accept the laws as a fact of life.

I like a happy ending, don't you? Please join auxiliary and the nation in the effort to make America drug-free. Ask your spouse to support through auxiliary membership. Next month this page will detail alternative methods of membership and how you can help. ◀

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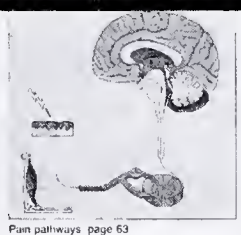
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Pain pathways page 63

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SPECIAL FEATURE

Willingway: A Fellowship in Alcoholism and Drug Addiction

Viewbox

(continued from page 42)

Diagnosis: Neutropenic typhlitis

Appendicitis is a possibility, but the extent of bowel involvement on CT and the absence of an inflammatory mass make periappendiceal abscess unlikely. An intramural hemorrhage of the cecum may present similarly. However, the irregularity of the thickened bowel walls with extension into the anterior and posterior pararenal spaces favor an inflammatory process.¹ In addition, acute hemorrhage would be more dense. Ogilvie's syndrome or colonic pseudo-obstruction is suggested by a progressively dilated cecum with thinning, not thickening, of the wall. Patients with leukemia are predisposed to pneumatosis intestinalis; however, this entity is asymptomatic and represents a less serious condition. It is thought that lymphoid depletion induced by steroids leads to air-cyst formation which may last for weeks and may progress to benign pneumoperitoneum secondary to cyst rupture.² The history of leukemia, RLQ pain, and thickening of the bowel wall without an inflammatory mass make neutropenic typhlitis the most likely diagnosis.

Typhlitis is a necrotizing inflammation of the typhlum (the Greek origin for cecum) associated with neutropenia, most often seen in acute leukemic patients on chemotherapy. This condition was first described and the term first used by Wagner, *et al.*, in 1970, as a rare gastrointestinal complication of leukemia in children.³ Adult occurrences were first described by DeFava, *et al.*, in 1977.⁴ Improved survival rates and more aggressive therapeutic regimens have increased the incidence of acute abdominal conditions associated with leukemia in the last decade.⁵ In addition to typhlitis, these conditions include appendicitis, intussusception, perforation and intestinal obstruction. Initially described as occurring only in the terminal stage of the disease, leukemic typhlitis is now known to occur at any point in the clinical course, and may even occur immediately after the first treatment with chemotherapy.^{6,7} Typhlitis has also been described with lymphoma,⁸ aplastic anemia,⁹ immunosuppressed post renal transplant patients,¹⁰ and agranulocytopenia caused by medication.^{11,12} In addition, we have seen typhlitis associated with Felty's syndrome.

Pathology

The cecum is the most distensible portion of the colon, and is also an area of relative stasis. The bowel mucosa, therefore, is prone to ischemic conditions brought about by distention and direct cytotoxic effects of chemotherapeutic agents due to stasis of colonic fluids.¹³ Ulceration, necrosis and architectural changes occur in the bowel mucosa as a result. In the presence of profound agranulocytopenia, a permissive milieu for bacterial, fungal and viral overgrowth is produced, leading to typhlitis.

Microscopically, there appear to be three anatomic patterns: (1) confinement to the cecum only; (2) involvement of the cecum and more distal colon (the terminal ileum and appendix are usually spared,

although their involvement does occur); (3) ulcerative lesions scattered throughout the large and small bowel.³

Microscopic studies have revealed acute and chronic necrotizing transmural inflammation of the cecum with multiple microperforations. No evidence of hemorrhage or leukemic infiltrate is usually identified.¹⁴ Cultures obtained from the cecum at surgery are almost invariably positive, and most commonly grow *Pseudomonas aeruginosa* and *Candida albicans*. Cytomegalovirus has also been isolated.¹⁵

Clinical

Most commonly presenting symptoms include fever, abdominal pain and tenderness in the setting of profound neutropenia and cytotoxic chemotherapy. Fever usually lasts a minimum of 48 hours. Tenderness is most frequently localized in the right lower quadrant. In addition, approximately half of patients with typhlitis experience watery diarrhea which may become bloody. Occasionally, a mass may be palpated in the right lower quadrant representing the inflamed cecum.

In one series, all patients developed symptoms when the absolute neutrophil count was less than 100 cells/mm³. Recovery of the white blood cell count appears to coincide with remission of the symptoms. In another series, blood culture drawn at onset of symptoms was positive in 7 out of 25 patients (36%). All organisms recovered were intestinal flora; *E. coli* was the most common.

Radiology

On the plain film, Wagner described a paucity of bowel gas in the right lower quadrant with a right-sided, ill-defined, soft tissue density thought to represent a fluid-filled atonic ascending colon.³ The adjacent small bowel is slightly distended in the early stages, progressing to a small bowel ileus in later stages. Subsequent reports describe a right-sided soft tissue density abdominal mass in combination with small bowel distention as the most frequent plain film finding.^{3,7,15,16} A rare but important plain film presentation of typhlitis was described by Cronin and DeFava, in which a dilated, distended cecum was observed, indicating a surgically emergent condition known as toxic typhlitis.¹⁴

Barium enemas show irregular thickening of the mucosal folds in the cecum and "thumb printing" secondary to bowel wall edema and cecal contraction.⁴ If a normal appendix is filled by barium, an important diagnostic possibility of acute appendicitis is excluded.¹⁷

Meyerovitz and Fellows described arteriographic findings of hypervascularity of the cecum with intense mucosal staining, opacification of superficial ulcers and arteriovenous shunting in dilated mesenteric veins.¹⁸

On ultrasound, note the "target" pattern in the cecal area indicating the presence of a rounded mass

with a hyperechogenic center and a wide hypoechoic periphery. However, this sign is nonspecific, since it is also encountered with malignant tumors of the gastrointestinal tract, inflammatory bowel disease, intussusception with bowel infarction and in intramural hemorrhage.⁷

CT reveals a uniform and diffusely thickened cecal wall with variable extension along the ascending colon. At times, intramural areas of lower density are noted and thought to represent edema or previous hemorrhage. In more advanced cases, involvement of the pararenal spaces and mesenteric tissue reactions are seen. A decrease in cecal wall thickness on CT often coincides with clinical improvement and the return of adequate numbers of neutrophils.^{1,19}

Management and Treatment

There has not yet been a consensus on the management of neutropenic typhlitis in more advanced cases. The controversy is related to circumstance and exact timing for surgical intervention. The current trend favors conservative management, consisting of the suspension of chemotherapy and supportive care.^{5,15} When there is profuse gastrointestinal hemorrhage, free perforation of the bowel wall, or impending rupture as in toxic typhlitis, early surgical intervention is indicated.²⁰

Conclusion

With the increasing incidence of typhlitis, the possibility of this diagnosis should be actively considered in neutropenic patients with abdominal pain. Recent onset of abdominal pain, tenderness or right lower quadrant mass occurring in a leukemic patient on chemotherapy or in an immunocompromised patient with other causes of neutropenia should lead to a plain film study. This may suggest findings compatible with typhlitis. A barium enema of the colon or a CT scan may confirm the diagnosis. In the presence of suspected toxic cecitis, a barium enema should not be done because of the danger of perforation.

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Continuing Education for Medical Assistants

by ROBIN BLUESTEIN, CMA-C

The bylaws of the Illinois Society, American Association of Medical Assistants state, "The purpose of this society shall be to promote the professional identity and stature of its members, and the medical assisting profession, through education and credentialing."

Last month's column featured credentialing and the requirements needed to become a Certified Medical Assistant (CMA). Continuing education is one way to revalidate the CMA credential. This month's article describes the forms of continuing education available.

Medical assistants believe in the importance of updating their medical knowledge through continuing education. With the changes occurring in the medical field, both administratively and clinically, medical assistants must keep current by taking courses, reading journals and meeting with their peers.

Many colleges offer continuing education courses. Triton College in River Grove, Illinois, is offering an insurance coding course (Janua-

ry-March) and an industrial audiometry course (March-May). Harper College in Palatine, Illinois, offered ICD-9 and CPT coding courses and will be offering a course in insurance and coding this spring. In addition to the knowledge gained, these courses can be applied for credit toward certification revalidation.

The American Association of Medical Assistants also offers continuing education opportunities. On the local, state and national levels, seminars are presented of interest to the medical assistant. "How to Deal with the Problem Patient" and "New Advances in Contraception" are possible program topics that may be available to help the medical assistant in her/his profession. In addition, continuing education courses may be purchased by mail. "Anatomy, Terminology and Physiology," "Human Relations for the Medical Office" and "Law for the Medical Office" are several of the courses offered. Another source of information is

The Professional Medical Assistant (the AAMA journal), which offers many interesting and informative articles.

Finally, peers in their local chapters can lend medical assistants ideas in the day-to-day operation of their offices. These individuals are dedicated to their profession, concerned about their patients and willing to learn about the changes occurring through continuing education.

For further information regarding continuing education and the Illinois Society of Medical Assistants, please contact: Continuing Education, AAMA, 20 North Wacker Drive, Suite 1575, Chicago 60606; or Cheryl Hutchison, CMA, ISMA president, 53 Lockhaven, Granite City 62040; or the public relations co-chairpersons: Lesa Hildebrand, Ed.M., CMA-C, Triton College, 2000 Fifth Avenue, River Grove 60171 or Lucille Perce, CMA-C, 22W 384 Teakwood, Glen Ellyn 60137. ◀

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 782-1654.

February

Allergy

Physical Urticaria: New Concepts
For: Interested physicians. Lecture, February 15, Holiday Inn, Chicago City Centre. **Sponsor:** Illinois Society of Allergy and Clinical Immunology, 800 E. Northwest Hwy., Suite 1080, Palatine, IL 60067. **Fee:** \$20 (dinner). **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** Diane Kubis. **Phone:** (312) 359-3090.

Internal Medicine

Silent Ischemia
For: Interested physicians. Lecture, February 2, DeKalb, IL. **Sponsors:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115 and Pfizer Laboratories. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour; AAFP Prescribed: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, Ext. 3484.

Evolution of Cholesterol Awareness/New Therapeutic Strategies
For: Interested physicians. Lecture, February 16, DeKalb, IL. **Sponsors:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115 and Merck Sharp & Dohme. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour; AAFP Prescribed: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, Ext. 3484.

Ophthalmology

Laser Treatment for Common Fundus Diseases
For: Ophthalmologists. Workshop, February 12-13, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME, 465A WARF Bldg., 610 Walnut Street, Madison, WI 53705, and Dept. of Ophthalmology, School of Medicine, University of Wisconsin-Madison. **Fee:** To be determined. **Reg. Limit:** 48. **Credit:** Category 1: 14 hours; other: University of Wisconsin CEU's: 14 hours. **Contact:** Cathy Means. **Phone:** (608) 263-6637.

Pathology

Histological Determinance of Breast Cancer Risk
For: Pathologists. Lecture, February 8, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Dept. of Pathology, Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644, and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours for Chicago Pathology Society members only. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5716.

Pediatrics

Usage of Pediatric Antibiotics
For: Pediatricians. Lecture, February 23, DeKalb, IL. **Sponsors:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115, and Roche Laboratories. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour; AAFP Prescribed: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, ext. 3484.

Psychiatry

The Psychiatric Interview
For: Psychiatrists. Course, February 26-28, Holiday Inn, Mart Plaza, Chicago. **Sponsor:** University of Chicago School of Medicine, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** \$375. **Reg. Limit:** 150. **Credit:** Category 1: 18 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

March

Clinical

44th Annual Midwest Clinical Conference
For: Physicians of all specialties. Conference, March 4-6, Palmer House, Chicago. **Sponsor:** Chicago Medical Society, 515 N. Dearborn, Chicago, IL 60610, and over 40 contributing specialties. **Fee:** Discounts for ISMS and CMS members. **Reg. Limit:** None. **Credit:** Category 1: 20 hours. **Contact:** Judy Beazley. **Phone:** (312) 670-2550 X 204.

Family Medicine

Perspectives in Primary Care
For: Primary care physicians and internists. Conference, March 25-26, Champaign, IL. **Sponsor:** University of Illi-

nois College of Medicine-Urbana. **Fee:** \$165. **Reg. Limit:** 150. **Credit:** Category 1: 12.5 hours; AAFP Prescribed: 12.5 hours. **Contact:** James Leonard, M.D., 2011 Round Barn Road, Champaign, IL 61821. **Phone:** (217) 337-3322.

Hematology/Oncology/Internal Medicine

Advances in Autologous Bone Marrow Transplant
For: Hematologists, oncologists, and internists. Lecture, March 19, Marriott Oakbrook, Oak Brook, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** \$20. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Internal Medicine

Early Intervention in Acute Myocardial Infarction
For: Cardiologists and internists. Lecture, March 16, Holiday Plaza Complex, Matteson, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** \$65. **Reg. Limit:** 150. **Credit:** Category 1: 6 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Internal Medicine Review

For: Internists. Symposia, March 7-May 21, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** \$300. **Reg. Limit:** 225. **Credit:** Category 1: 36 hours; AAFP Prescribed: 36 hours; ADA: 36 hours. **Contact:** Loretta Giaconetto. **Phone:** (800) 325-9862.

Ophthalmology

Fluorescein Angiography Workshop
For: Ophthalmologists. Workshop, March 11-12, Madison, WI. **Sponsor:** University of Wisconsin-Madison, CME 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** 35. **Credit:** Category 1: 14 hours; other: University of Wisconsin CEU's: 14 hours. **Contact:** Cathy Means. **Phone:** (608) 263-6637.

Pathology

Neoplastic Lymph Node Pathology
For: Pathologists. Seminar, March 14, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Pathology Dept., Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644, and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours for Chicago Pathology Society members only. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5716.

Radiology

Imaging Modalities in the Chest and Abdomen
For: Radiologists. Symposium, March 20-25, Maui, Hawaii. **Sponsor:** Loyola University Stritch School of Medicine, Division of CME, 2160 S. First Avenue, Maywood, IL 60153. **Fee:** \$485. **Reg. Limit:** 200. **Credit:** Category 1: 20 hours. **Contact:** Linda K. Gunzburger, Ph.D. **Phone:** (312) 531-3236.

April

Allergy

Hypersensitivity to Penicillins and Cephalosporins
For: Interested physicians. Lecture, April 18, Holiday Inn, Chicago City Centre. **Sponsor:** Illinois Society of Allergy and Clinical Immunology, 800 E. Northwest Hwy., Suite 1080, Palatine, IL 60067. **Fee:** \$20 (dinner). **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** Diane Kubis. **Phone:** (312) 359-3090.

Cardiology

Eighth Annual Great Lakes Conference on High Blood Pressure
For: Interested physicians. Conference, April 18-20, Ann Arbor, MI. **Sponsors:** American Heart Association of Michigan, P.O. Box 160, Lathrup Village, MI 48076, and the Michigan Department of Public Health. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: To be determined. **Contact:** Tom Matz. **Phone:** (313) 557-9500.

sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

Family Medicine/Gynecology

Geriatric Gynecology for the Primary Care Provider
For: Family practitioners and internists. Course, April 16, Merrillville, IN. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** \$25. **Reg. Limit:** 200. **Credit:** Category 1: 6 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Hematology/Oncology

Lymphoma 1988: New Diagnostic and Treatment Strategies
For: Interested physicians. Symposium, April 15, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** \$20. **Reg. Limit:** 200. **Credit:** Category 1: 6 hours; AAFP Prescribed: 6 hours; ADA: 6 hours. **Contact:** Loretta Giaconetto. **Phone:** (800) 325-9862.

Internal Medicine/Family Medicine

Clinical Endocrinology '88
For: Internists and family practitioners. Lecture, April 9, Hyatt Regency Oakbrook, Oak Brook, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 6 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Neuroradiology

1988 Neuroradiology Review Course
For: General radiologists, neuroradiologists, neurosurgeons, neurologists, and residents. Course, April 30-May 1, Oakbrook Marriott Hotel, Oak Brook, IL. **Sponsors:** Loyola University Stritch School of Medicine, Dept. of CME and Department of Radiology, 2160 S. First Avenue, Maywood, IL 60153. **Fee:** \$170 for physicians, \$100 for residents. **Reg. Limit:** None. **Credit:** Category 1: 16 hours. **Contact:** Linda K. Gunzburger, Ph.D. **Phone:** (312) 531-3237.

Obstetrics/Gynecology

15th Annual Symposium on Obstetrics and Gynecology
For: Interested physicians. Symposium, April 28-29, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** \$200. **Reg. Limit:** 150. **Credit:** Category 1: 12 hours; AAFP Prescribed: 12 hours; ADA: 12 hours; ACOG cognates: 12 hours. **Contact:** Loretta Giaconetto. **Phone:** (800) 325-9862.

Ophthalmology

Advanced Contact Lens Course
For: Ophthalmologists. Seminar, April 20-21, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** To be determined. **Reg. Limit:** 150. **Credit:** Category 1: 9 hours. **Contact:** Loretta Giaconetto. **Phone:** (800) 325-9862.

Otolaryngology

Frontiers of Medicine: Recent Progress in Head and Neck Oncology
For: Otolaryngologists. Course, April 13, Chicago. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** 150. **Credit:** Category 1: 6 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Pathology

Future Trends in Evaluating Quality of Care
For: Pathologists. Lecture, April 11, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644, and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours for Chicago Pathology Society members only. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

Urology

Frontiers in Endoscopy
For: Urologists. Workshop, April 15-16, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** To be determined. **Reg. Limit:** 80. **Credit:** Category 1: 11 hours. **Contact:** Loretta Giaconetto. **Phone:** (800) 325-9862.

ISMS Physician Help Line

Are you troubled by chemical dependency, alcoholism, physical or mental problems, or concerned about someone who has an impairment? Are you having emotional or physical problems dealing with your involvement in a malpractice suit?

If so, contact the PHYSICIAN HELP LINE, 312/580-2499, a confidential, advocacy service offered by the ISMS Impaired Physician Program and the Physician Support Group to link troubled physicians and their families with resources to help them.

Physician Help Line calls will be answered, as soon as possible, by Dr. Violet M. Eggert, Medical Director of the ISMS Impaired Physician Program.

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TWENTY-NINE PHYSICIAN multispecialty clinic located in desirable east central Wisconsin location is seeking board certified or board qualified orthopedic surgeon to round out its services. Lab, x-ray, excellent hospital. Liberal guarantee and benefits. If interested contact D. F. Sweet, M.D., Fond du Lac Clinic, S.C., 80 Sheboygan Street, Fond du Lac, Wisconsin 54935.

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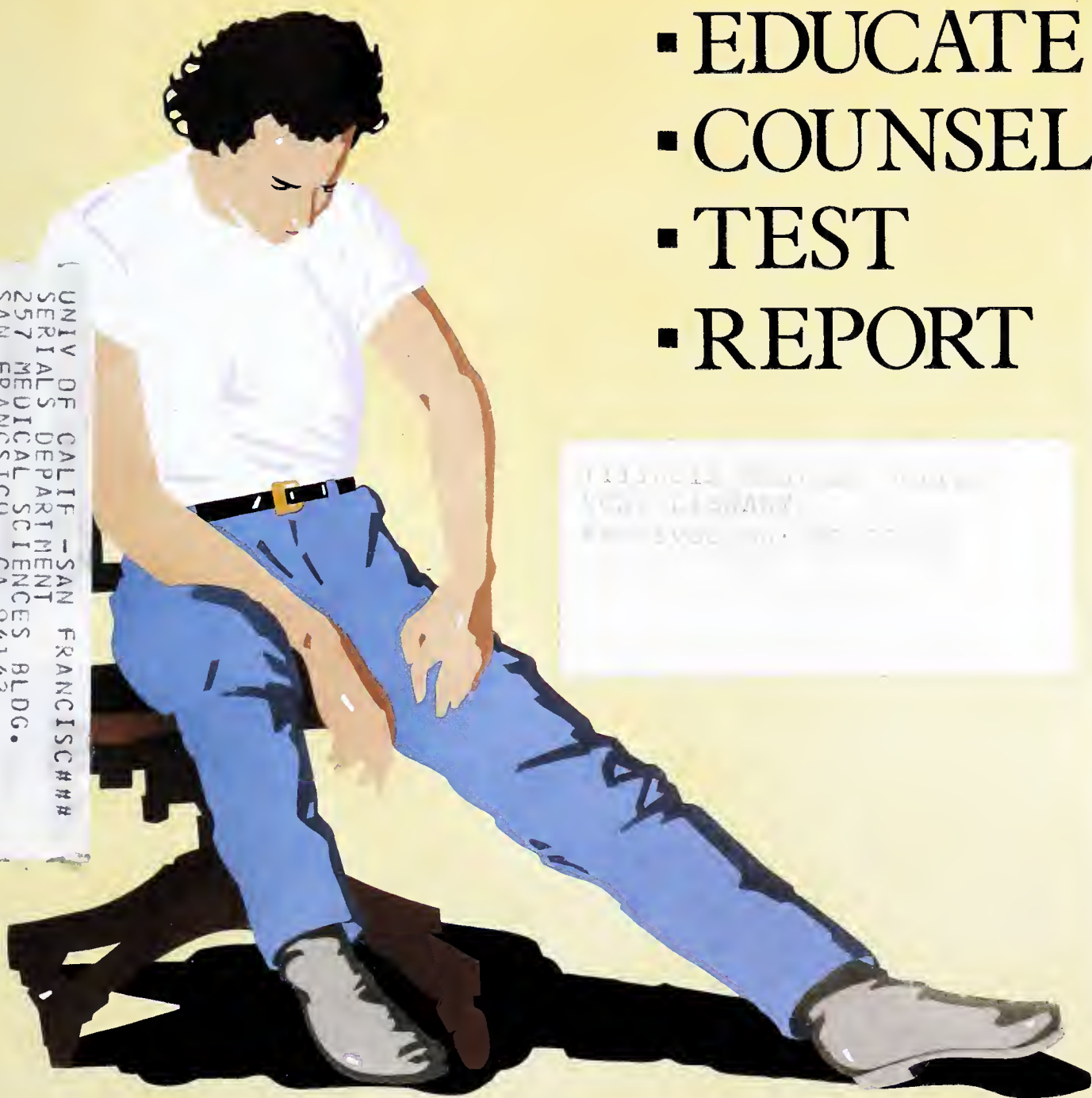
Official Journal of the Illinois State Medical Society

Volume 173, Number 2, February 1988

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We may bitch about the hours, the paperwork, the dumb routines and the intrusions of third parties but we love what we do. Moreover, we all earn good money doing what we enjoy and our families are provided for. We work hard, the money comes in, the bills are paid, the savings grow and few of us worry about mundane subjects such as management skills, marketing, "bottom lines" and losing our jobs. We get a charge out of making an astute diagnosis in a difficult situation, working with wit and humor and pulling off a tough job or surgical chore successfully. We all work for nothing some of the time. Most of us know it is useless and counter-productive to worry about the money part of medicine, the fee-for-service. We try to be businesslike and do what our management consultants and medical economists urge us to do but these are not our primary concerns.

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Edward J. Fesco, M.D.

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Brief Summary

CLINICAL PHARMACOLOGY: Pharmacodynamics: Clinical studies of terazosin used in once-a-day (majority) and b.i.d regimens with total doses usually in the range of 5-20mg/day, in patients with mild or moderate hypertension. Because terazosin, like all alpha antagonists, can cause large falls in blood pressure after the first dose or first few doses, the initial dose was 1mg in virtually all studies, with subsequent titration to a specified fixed dose or titration to a specified blood pressure end point.

Blood pressure responses were measured at the end of the dosing interval (usually 24 hrs.) and effects were shown to persist throughout the interval, with usual supine responses 5-10mmHg systolic and 3.5-8mmHg diastolic greater than placebo. The responses in the standing position tended to be somewhat larger, although this was not true in all studies. The magnitude of blood pressure responses was similar to prazosin and less than hydrochlorothiazide (in a single study). In measurements 24 hrs. after dosing, heart rate was unchanged.

Limited measurements of peak response (2-3 hrs. after dosing) during chronic terazosin administration indicate that it is more than twice the trough (24 hr.) response, suggesting some attenuation of response at 24 hrs., presumably due to a fall in blood terazosin concentrations at the end of the dose interval. This explanation is not established with certainty and is not consistent with the similarity of blood pressure response to once-a-day and b.i.d. dosing. With the absence of an observed dose-response relationship over a range of 5-20mg, i.e., if blood concentrations fall to the point of providing less than full effect at 24 hrs., a shorter dosing interval or larger dose should lead to increased response. Measure blood pressure (BP) at the end of the dose interval; if response is not satisfactory, patients may be tried on a larger dose or b.i.d. regimen. The latter should be considered if side effects, such as dizziness, palpitations, or orthostatic complaints, are seen within a few hours after dosing.

The greater BP effect associated with peak plasma concentrations (first few hours after dosing) appears somewhat position-dependent (greater in the erect position) than the effect of terazosin at 24 hrs. In the erect position there is a 6-10 mm increase in heart rate in the first few hours after dosing. During the first 3 hrs. after dosing 12-5% of patients had a systolic pressure fall of 30mmHg or more from supine to standing, or standing systolic pressure below 90mmHg with a fall of at least 20mmHg, compared to 4% of a placebo group.

INDICATIONS AND USAGE: Indicated for the treatment of hypertension.

CONTRAINDICATIONS: None known.

WARNINGS: Syncope and "First-dose" Effect: Terazosin, like other alpha-adrenergic blocking agents, can cause marked hypotension, especially postural hypotension, and syncope in association with the first dose or first few doses. A similar effect may occur if therapy is interrupted for more than a few doses. Syncope has been reported with other alpha-adrenergic blocking agents in association with rapid dosage increases or introduction of another antihypertensive drug. Syncope may be due to an excessive postural hypotensive effect, although occasionally the syncopal episode has been preceded by severe supraventricular tachycardia with heart rates of 120-160 bpm.

To decrease the likelihood of syncope or excessive hypotension, always initiate treatment with a 1mg dose at bedtime. The 2mg and 5mg tablets are not indicated as initial therapy. Increase dosage slowly, and add additional antihypertensive agents with caution. Caution patients to avoid situations where injury could result if syncope occurs during initiation of therapy.

In early studies, where increasing single doses up to 7.5mg were given at 3 day intervals, tolerance to the first dose phenomenon did not necessarily develop and the "first dose" effect was observed at all doses. Syncopal episodes occurred in 3 of 14 subjects given doses of 2.5, 5, and 7.5mg, which are higher than the recommended initial dose. Severe orthostatic (BP 50/0mmHg) was seen in two others and dizziness, tachycardia, and lightheadedness occurred in most subjects. These adverse effects all occurred within 90 min. of dosing.

In multiple dose clinical trials involving nearly 2000 patients, syncope was reported in about 1% of patients, in no case severe or prolonged, and was not necessarily associated with early doses.

If syncope occurs, place patient in recumbent position and treat supportively. There is evidence that the orthostatic effect of terazosin is greater, even in chronic use, shortly after dosing.

PRECAUTIONS: General: **Orthostatic Hypotension:** While syncope is the most severe orthostatic effect of terazosin, other symptoms of lowered BP, such as dizziness, lightheadedness and palpitations, are more common, occurring in 28% of patients in clinical trials. Patients with occupations in which such events represent potential problems should be treated with particular caution.

Information for Patients: Make aware of possibility of syncopal and orthostatic symptoms, especially at initiation of therapy, and to avoid driving or hazardous tasks for 12 hrs. after the first dose, after a dosage increase, and after interruption of therapy when treatment is resumed. Caution to avoid situations where injury could result should syncope occur during initial therapy. Advise to sit or lie down when symptoms of lowered BP occur and to rise carefully from a sitting or lying position. Bothersome dizziness, lightheadedness, or palpitations should be reported to physician.

Tell patients that drowsiness or somnolence can occur, requiring caution in people who must drive or operate heavy machinery.

Laboratory Tests: Small but statistically significant decreases in hematocrit, hemoglobin, WBC, total protein and albumin were observed in clinical trials. The magnitude of decreases did not worsen with time. These findings suggest the possibility of hemodilution.

Drug Interactions: In controlled trials, terazosin was added to diuretics, and several beta-adrenergic blockers, no unexpected interactions were observed. Terazosin has also been used concomitantly without interaction in at least 50 patients on the following: 1) analgesic/anti-inflammatory (acetaminophen, aspirin, codeine, bupropion, indomethacin), 2) antibiotics (erythromycin, trimethoprim and sulfamethoxazole), 3) anticholinergic/sympathomimetics (phenylephrine HCl, phenylpropanolamine HCl, pseudoephedrine HCl), 4) antiparkinsonian (lisdopamine), 5) antihistamines (chlorpheniramine), 6) cardiovascular agents (atenolol, hydrochlorothiazide, methylclothiazide, propranolol), 7) corticosteroids, 8) gastrointestinal agents (antacids), 9) hypoglycemics, 10) sedatives and tranquilizers (diazepam).

Carcinogenesis, Mutagenesis, Impairment of Fertility: HYTRIN was devoid of mutagenic potential when evaluated *in vivo* and *in vitro*.

HYTRIN, administered in feed to rats at doses of 8, 40, and 250mg/kg/day for 2 yrs, was associated with a statistically significant increase in benign adrenal medullary tumors of male rats exposed to the 250mg/kg dose. This dose is 695 X max. recommended human dose (20mg/55kg). Female rats were unaffected. HYTRIN was not oncogenic in mice when administered in feed for 2 yrs at a maximum tolerated dose of 32mg/kg/day.

The absence of mutagenicity in a battery of tests, of tumorigenicity of any cell type in the mouse carcinogenicity assay, of increased total tumor incidence in either species, and of proliferative adrenal lesions in female rats, suggests a male rat species specific event. Numerous other diverse pharmaceutical and chemical compounds have been associated with these tumors in male rats without supporting evidence for carcinogenicity in man.

Effects on fertility were assessed in a standard fertility/reproductive performance study in which male and female rats were administered oral doses of 8, 30 and 120mg/kg/day. Four of 20 male rats given 30mg/kg and 5 of 19 male rats given 120mg/kg failed to sire a litter. Testicular weights and morphology were unaffected. Vaginal smears at 30 and 120mg/kg/day appeared to contain less sperm than smears from control matings and good correlation was reported between sperm count and subsequent pregnancy.

Oral use for 1 or 2 yrs. elicited a statistically significant increase in testicular atrophy in rats exposed to 40 and 250mg/kg/day, but not in rats exposed to 8mg/kg/day (> 20 X max. recommended human dose). Testicular atrophy was observed in these doses in male rats without supporting evidence for carcinogenicity in man.

After 1 yr. when dosed with 20mg/kg/day. This lesion has also been seen with Minipress®.

Pregnancy: Teratogenic effects: Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women and the safety of terazosin in pregnancy has not been established. HYTRIN is not recommended during pregnancy unless potential benefit justifies potential risk to mother and fetus.

Nonteratogenic effects: In a peri- and post-natal development study in rats, significantly more pups died in the group dosed with 120mg/kg/day (> 300 X max. recommended human dose) than in the control group during the 3 week post-partum period.

Nursing Mothers: It is not known whether terazosin is excreted in breast milk, therefore, exercise caution when administering terazosin to a nursing woman.

Pediatric Use: Safety and effectiveness have not been determined.

ADVERSE REACTIONS: The prevalence of adverse reactions has been ascertained from 14 placebo-controlled studies conducted primarily in the U.S. The studies involved once-a-day administration of terazosin as monotherapy or in combination with other antihypertensive agents, at doses ranging from 1 to 40mg. All adverse events reported during these studies were recorded as adverse reactions. Adverse events where the prevalence rate in the terazosin group was at least 5%, where the prevalence rate for the terazosin group was at least 2% and was greater than the prevalence rate for the placebo group, or where the reaction is of particular interest are summarized below. Only asthenia, blurred vision, dizziness, nasal congestion, nausea, peripheral edema, palpitations and somnolence were significantly (p < 0.05) more common in patients receiving terazosin than in patients receiving placebo. Other events include: [%TERAZOSIN-PLACEBO]: asthenia (1.3%-4.3%), back pain (2.4%-1.2%), blurred vision (1.6%-0.0%), depression (0.3%-0.2%), dizziness (19.3%-7.5%), dyspnea (3.1%-2.4%), edema (0.8%-0.6%), headache (16.2%-15.8%), impotence (1.2%-1.4%), libido decreased (0.6%-0.2%), nasal congestion (5.9%-3.4%), nausea (4.4%-1.4%), nervousness (2.3%-1.8%), pain-extremities (3.5%-3%), palpitations (4.3%-1.2%), paresthesia (2.9%-1.4%), peripheral edema (5.5%-2.4%), postural hypotension (1.3%-0.4%), sinusitis (2.6%-1.4%), somnolence (5.4%-2.6%), tachycardia (1.9%-1.2%), weight gain (0.5%-0.2%).

Adverse reactions were usually mild or moderate in intensity but sometimes were serious enough to interrupt treatment. Adverse reactions that were most bothersome as judged by being reported as reasons for discontinuation of therapy by at least 0.5% of the terazosin group and being reported more often than in the placebo group [%TERAZOSIN-PLACEBO] are: asthenia (1.6%-0%), blurred vision (0.6%-0%), dizziness (3.1%-0.4%), dyspnea (0.9%-0.6%), headache (1.3%-1%), nasal congestion (0.6%-0%), nausea (0.8%-0%), palpitations (1.4%-0.2%), paresthesia (0.8%-0.2%), peripheral edema (0.6%-0%), postural hypotension (0.5%-0%), somnolence (0.6%-0.2%), syncope (0.5%-0.2%), tachycardia (0.6%-0%).

Additional adverse reactions have been reported, but these are not distinguishable from symptoms that might have occurred in the absence of exposure to terazosin. The following additional adverse reactions were reported by at least 1% of 1987 patients who received terazosin in clinical studies or during marketing experience: abdominal pain, abnormal vision, anxiety, arrhythmia, arthralgia, arthritis, bronchitis, chest pain, cold symptoms, constipation, dizziness, dry mouth, dyspepsia, epistaxis, facial edema, fever, flatulence, flu symptoms, gout, increased cough, insomnia, joint disorder, myalgia, neck pain, pharyngitis, pruritus, rash, rhinitis, shoulder pain, sweating, tinnitus, urinary frequency, urinary tract infection, vasodilation, vomiting.

DOSSAGE AND ADMINISTRATION: Dose and dose interval (12 or 24 hrs.) should be adjusted according to BP response.

Initial Dose: 1mg at bedtime. Observe the initial dosing regimen strictly to minimize potential for severe hypotensive effects.

Subsequent Doses: Slowly increase dose to achieve desired BP response. Usual dose range is 1mg to 5mg once a day. Some patients may benefit from doses up to 20mg/day. Doses over 20mg do not appear to provide further BP effect. Doses over 40mg have not been studied. Monitor BP at the end of dosing interval to assure control is maintained. It may be helpful to measure BP 2-3 hrs. after dosing to see if maximum and minimum responses are similar, and to evaluate symptoms which can result from excessive hypotensive response. If response is substantially diminished at 24 hrs. consider an increased dose or b.i.d. regimen. If administration is discontinued for several days or longer, reinstitute therapy using initial dosing regimen. In clinical trials, except for the initial dose, the dose was given in the morning.

Use With Other Drugs: Caution should be observed when terazosin is administered concomitantly with other antihypertensive agents (e.g., calcium antagonists) to avoid the possibility of significant hypotension. When adding a diuretic or other antihypertensive agent, dosage reduction and retitration may be necessary.

August, 1987 Abbott Health Care Products, Inc. North Chicago, IL 60064 7083834

REFERENCES:

1. Burell CO, Levy RA. Therapeutic consequences of noncompliance, in: *Improving Medication Compliance. Proceedings from a Symposium*, Reston, VA, National Pharmaceutical Council, 1984, pp 7-16.

2. Spertzel WO, Glassman HN, Jordan OC, et al: Overall safety of terazosin as an antihypertensive agent. *Am J Med* 1986;80(suppl 5B):77-81.

3. Data on file, Abbott Pharmaceuticals

4. Deger G: Effect of terazosin on serum lipids. *Am J Med* 1986;80 (suppl 5B) 82-85 7083834

Quit Smoking Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state.

The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 1440 W. Washington Blvd., Chicago 60607. Telephone (312) 243-2000.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

In addition, the American Cancer Society provides Fresh Start clinic training anywhere in Illinois for hospitals and industries. Educational materials, pamphlets, posters, films and training can also be obtained at no charge. For information, contact your local ACS office, or the Illinois Division, Inc., at 37 South Wabash Ave., Chicago 60603; (312) 372-0471.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

March 1	Rush North Shore Med. Ctr.	Skokie
March 1	VA Lakeside Med. Ctr.	Chicago
March 8	Carle Clinic	Urbana
April 4	Alexian Bros. Med. Ctr.	Elk Grove
To Be Announced	Ambutal	Crystal Lake
To Be Announced	Copley Memorial Hospital	Aurora
To Be Announced	Delnor Community Hospital	Geneva and St. Charles
To Be Announced	Dreyer Clinic	Aurora
To Be Announced	Field Medical Group	Chicago
To Be Announced	Highland Park Hospital	Highland Park
To Be Announced	Hinsdale Hospital	Hinsdale
To Be Announced	Memorial Hospital for McHenry County	Woodstock
To Be Announced	Mendota Community Hospital	Mendota
To Be Announced	Northern Illinois Med. Ctr.	McHenry
To Be Announced	Ravenswood Health Care Ctr.	Chicago
To Be Announced	Resurrection Health Hospital	Chicago
To Be Announced	Sherman Hospital	Elgin
To Be Announced	West Town Public Health Clinic	Chicago

Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

Contraindications: There are no known contraindications to the use of 'Tagamet'.

Precautions: While a weak antilindrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chloridiazepoxide, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.),

demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported. Including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly un-

likely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only), and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

Liquid: 300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).

Injection:

Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage® Vials: 300 mg./2 ml. in single-dose, ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl (brand of cimetidine hydrochloride) injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

* ADD-Vantage® is a trademark of Abbott Laboratories.

BRS-TG:L73B

Date of Issuance Apr. 1987

SK&F LAB CO.

Cidra, P.R. 00639

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In peptic ulcer:

RELIEF

REASSURANCE

REWARD



Tagamet[®]
brand of cimetidine
First to Heal

You'll both feel good about it.

RESULTS

SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies. This information was gathered through correspondence or by ISMS representatives and staff who attend meetings on behalf of Illinois physicians.

From the Department of Professional Regulation (DPR) (Formerly Registration and Education)

Controlled Substance Recordkeeping Requirements

The state has adopted an amended rule on physician records for dispensing and administering controlled substances. The rule changes the methods physicians use to maintain their Patient Controlled Substances Records (PCSRs) for schedules II through V.

Previously, such records were to be kept alphabetically by the patient's last name. The new rule now requires that these records be kept alphabetically by *drug or substance, with a separate record for each dosage form.*

In addition, for each instance of dispensing or administering, the PCSR must contain an entry with the following information:

1. The date of dispensing or administering;
2. *The name of the patient to whom the drug or substance was dispensed or administered;*
3. The quantity (number of units or volume) dispensed or administered; and
4. The name or initials of the individual who dispensed or administered the controlled substances on behalf of the individual practitioner, if not dispensed or administered by the practitioner himself.

Please note: These two italicized rule changes should be incorporated into page eight of the booklet recently

sent to physicians: *Prescribing, Dispensing and Administering Controlled Substances.*
(Source: Memo from DPR)

From the Illinois Department of Public Health (IDPH)

Emergency and Proposed Rules to Implement the AIDS Laws

IDPH has adopted emergency rules, effective January 1, 1988, for 150 days, which describe how physicians and others are to comply with new laws passed in the last legislative session dealing with HIV testing procedures. A summary of these regulations and the forms suggested by the state are provided in a special article beginning on page 92.

In addition, the state has published for public comment proposed rules on the implementation of the other AIDS laws, including the following topics: reporting requirements for AIDS, ARC and HIV infectivity; definitions of AIDS and HIV; contact tracing and counseling; isolation situations; examination of prisoners; requirements on contaminated or possibly infectious blood or specimens; safety requirements for blood banks; changes in the blood labeling act; and registration of sperm and tissue banks.

Persons wishing to receive copies of these rules should contact the IDPH Office of Governmental Affairs. Public hearings on these rules will be held in February at various sites around the state.

A better alternative for hypertensives who are going bananas...

Spare your patients the extra cost—
in calories, sodium and dollars.

Spare your patients the rigors of
dietary K⁺ supplementation.

DYAZIDE[®]

25 mg Hydrochlorothiazide/50 mg Triamterene/SKF

Effective antihypertensive*
therapy...without
the bananas

DAW
'DYAZIDE' AS WRITTEN.

* Not for initial therapy. See brief summary

Before prescribing, see complete
prescribing information in
SK&F CO. literature or PDR.
The following is a brief summary.

WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia, pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or

without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids; and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The

following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth, anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis; and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ-L45

a product of
SK&F CO.
Cidra, P.R. 00639

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State Supreme Court Takes Important Stand

ERISA Plans to Permit Assignment of Benefits to Physicians

The Illinois Supreme Court has determined that ERISA-qualified plans must permit direct assignment of employee health benefits to physicians when employees request it. Assignment of benefits, long associated with health insurance plans, will now be available to patients covered under ERISA-qualified plans. (ERISA-qualified plans are employer-sponsored health plans which meet requirements of the federal Employee Retirement Income Security Act of 1974.)

The Illinois Supreme Court has made an important ruling in ERISA benefits cases. Physicians can be assigned the rights of their patients to collect directly from the employer. This state court action is not pre-empted by federal law.

The Court took this action in reviewing a case from Rock Island County. In *Kennedy v. Deere & Company*,¹ a group of chiropractors sought to affirm their right to receive patient-assigned health care benefits provided under an ERISA-qualified plan. Deere, the employer, refused to recognize the assignments and claimed that a health care provider could be neither a beneficiary nor assignee of an ERISA-qualified health plan. Deere further contended that even if the health care provider were a beneficiary, it had no right to bring litigation

seeking to collect benefits payable under the plan.

The Rock Island County trial court dismissed the case and agreed with Deere. The appellate court reversed and was upheld by the Supreme Court.

This can be an important victory for physicians. In many instances, physicians in effect accept an assignment of rights under a health insurance plan to collect directly from the third party payor. Deere's contention was that they could not do this. Deere further stated that even if they could, and the employer were willing to recognize the assignment, physicians had no right to bring a cause of action to recover the sums due them. The Supreme Court pointed out that assignment is nowhere prohibited in the federal law and that federal and state courts

are granted concurrent jurisdiction with respect to ERISA.

One of Deere's concerns was that Section 502 of the ERISA law permits beneficiaries bringing a cause of action against the plan to recover attorney fees in addition to amounts due them. Deere contended that creditors and health care providers would bring action to recover expenses and attorney fees, harming the viability of the ERISA plan.

The significance of this decision is that ERISA-qualified plans in Illinois will have to think more carefully about denying benefits which are assigned by a patient. Not only can the provider sue to collect the monies due him or her, but attorney fees may be awarded as well. This decision could impact the collection of accounts for a significant number of physicians. ◀

References

1. *Kennedy v. Deere & Company*, Docket No. 63702, Supreme Court of Illinois, September 21, 1987.



The World's Most Popular K*

Slow-K[®]
potassium chloride
slow-release tablets
8 mEq (600 mg)

It means "dependability" in almost any language

*Based on worldwide sales data on file, CIBA Pharmaceutical Company.
Capsule or tablet slow-release potassium chloride preparations should be reserved for patients who cannot tolerate, refuse to take, or have compliance problems with liquid or effervescent potassium preparations because of reports of intestinal and gastric ulceration and bleeding with slow-release KCl preparations.

Before prescribing, please consult Brief Prescribing Information on next page.

C I B A

The World's Most Popular K

For good reasons

- **It works**—a 12-year record of efficacy¹
- **It's safe**—unsurpassed by any other KCl tablet or capsule^{2*}
- **It's acceptable vs liquids**—greater palatability, fewer GI complaints, lower incidence of nausea²
- **It's comparable to 10 mEq**—in low-dosage supplementation^{3†}
- **It's economical**—less expensive than all other leading KCl slow-release supplements on a per tablet cost to the patient¹



Slow-K[®]
potassium chloride
slow-release tablets 8 mEq (600 mg)

For patients who can't or won't tolerate liquid KCl.

*The most common adverse reactions to potassium salts are gastrointestinal side effects.

†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

C I B A

References: 1. Data on file, CIBA Pharmaceutical Company. 2. Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. 3. Skoutakis VA, Carter CA, Acchiardo SR. Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

Slow-K[®]
potassium chloride USP
Slow-Release Tablets
8 mEq (600 mg)

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

INDICATIONS AND USAGE

BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.
2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.
3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS

Hyperkalemia (See OVERDOSAGE).

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients

Physicians should consider reminding the patient of the following:

- To take each dose without crushing, chewing, or sucking the tablets.
- To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.
- To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.
- To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSAGE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED

Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K)

Bottles of 100 NOC 0083-0165-30

Bottles of 1000 NOC 0083-0165-40

Consumer Pack—One Unit

12 Bottles—100 tablets each NOC 0083-0165-65

Accu-Pak[®] Unit Dose (Blister pack)

Box of 100 (strips of 10) NOC 0083-0165-32

Do not store above 86°F (30°C). Protect from moisture. Protect from light.

Dispense in tight, light-resistant container (USP).

Dist. by:

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Division of CIBA-GEIGY Corporation
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C87-31 (Rev. 8/87)

C I B A

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THE INFORMED PHYSICIAN

THE INFORMED PHYSICIAN KNOWS WHAT QUESTIONS TO ASK, WHAT ISSUES TO RESOLVE AND WHEN TO CONSULT AN ATTORNEY, ACCOUNTANT OR ACTUARY WHEN CONSIDERING CONTRACTING WITH ALTERNATIVE DELIVERY SYSTEMS. THE ISMS OFFICE OF CONTRACTUAL SERVICES PRESENTS "THE INFORMED PHYSICIAN" AS AN EDUCATIONAL TOOL DESIGNED TO ILLUSTRATE, THROUGH REAL-LIFE SITUATIONS, THE SIGNIFICANT LEGAL AND ECONOMIC ISSUES WHICH FREQUENTLY ACCOMPANY CONTRACTS FOR THE DELIVERY OF HEALTH CARE, AND TO ALERT PHYSICIANS OF WAYS IN WHICH CONTRACTS MAY AFFECT THE PRACTICE OF MEDICINE.

From Time To Time

BY JUDEE GALLAGHER, J.D./CHICAGO

It may be a catchy phrase, but when these words appear in an HMO, PPO or IPA contract, forewarned is forearmed.

Sometimes it's the little words, the ones we hear in everyday conversation, that make the difference in a contract. They're so easy on the ear and familiar to the tongue that they can easily be overlooked. They're so easily understood, and so often used in common speech that you assume they either belong in the contract or are simply innocuous.

Think about the phrase "from time to time." From time to time you may visit your brother on the west coast or have waffles for breakfast. But how can the phrase "from time to time" affect your leverage or bargaining power with an HMO, PPO or IPA?

Consider this language:

Physician agrees to accept the utilization review program as adopted from time to time by PPO. As a part of the program Physician shall observe the protocols and be bound by utilization review decisions.

After careful examination, you may believe that it's possible to practice good quality medicine within the system. But there is no guarantee that unacceptable changes will not be made by the PPO "from time to time"—a day, a week, or a month after you have signed the contract. The "from time

to time" clause enables the PPO to make changes without your approval and imposes a contractual obligation to follow them.

The right to unilaterally alter the contract is, of course, a big advantage to an HMO, PPO or IPA. Competition within the health care industry is fierce. Employers and other payors are looking for new ways to control costs. Utilization review programs of HMO's, PPO's and IPA's furnish the industry with testing grounds for new cost containment efforts. But cost contain-

ment provisions? How will your cash flow be affected? Will the changes create a barrier to good quality medicine?

Significant compensation agreements are also sometimes subject to unilateral changes. Consider these examples:
*HMO shall initially withhold 20% of the Capitation Fee and may, from time to time, increase the percentage withheld as financial conditions necessitate; or
Physician shall accept the Primary Care Capitation Fee which may be changed from time to time by the IPA Board of Directors.*

Will you be able to break even or make a profit under the new pay-

Physicians are ultimately responsible for their medical decisions, and physician approval of the utilization review program makes sense.

ment must not jeopardize quality care. Physicians are ultimately responsible for their medical decisions, and physician approval of the utilization review program makes sense.

ment provisions? How will your cash flow be affected? Will the changes create a barrier to good quality medicine?

Often, contracts which contain
(continued on page 80)

HMO
PPO
IPA

Before
you
sign,
negotiate

Before
you
negotiate,
review



CONTRACT REVIEWS

The ISMS Office of Contractual Services reviews HMO, PPO and IPA contracts for members. The cost is \$100 per review.

Reviews do not constitute legal advice. They provide a working document which highlights key issues, such as malpractice coverage, reimbursement concerns and practice limitations.

For further information contact:

ISMS Office of Contractual Services
Twenty North Michigan Ave., Suite #700
Chicago, Illinois 60602
(312) 782-1654 or (800) 782-ISMS

Informed Physician

(continued from page 78)

one or several "from time to time" clauses also contain a separate provision (usually titled Amendments) which requires the written consent of both parties to any changes in the contract. It's easy to be lulled by this. But changes in the utilization review program which are made "from time to time" are not changes in the contract. They are specifically allowed by the contract. In this instance an amendment requiring the written consent of both parties could look like this: "PPO may *not* change the protocols, rules and procedures of the utilization review program without the written consent of Physician."

Because you're an informed phy-

sician who recognizes the complex issues involved in contracts for the delivery of medical care, your first step is to send the contract offered you or your IPA to the ISMS Office of Contractual Services. As a *members only service*, the office provides objective comments on any HMO, PPO or IPA contract for the nominal fee of \$100. Contract reviews highlight "standard of care," compensation and insurance issues, and pinpoint ambiguous language and inconsistent or contradictory provisions.

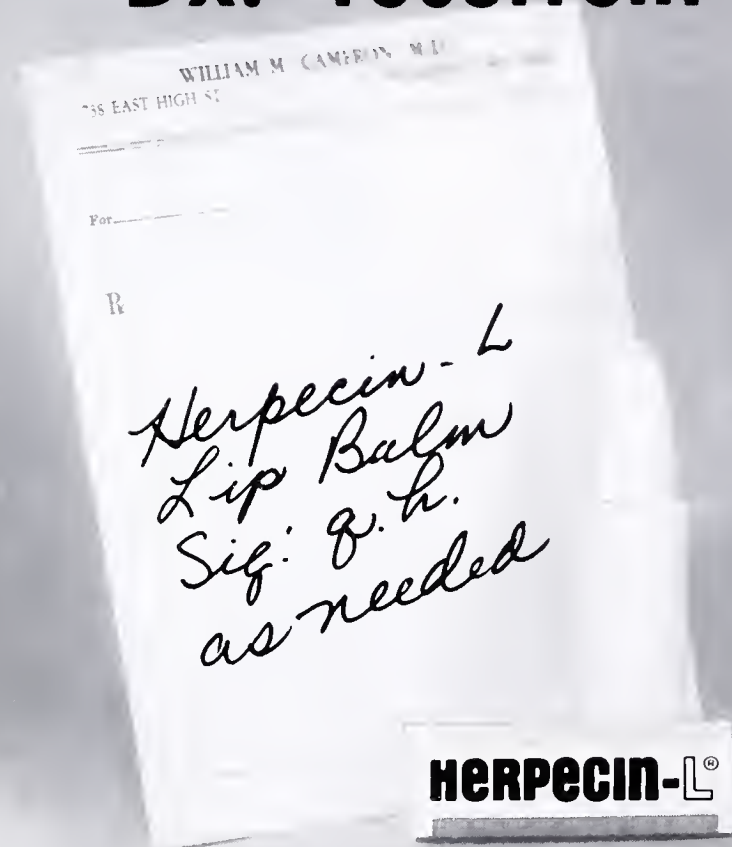
The review is a basic tool to help understand the contract. It's a good first step, but never a substitute for reading of the contract itself. It's not legal advice and the office cannot recommend that any contract is good or bad and should or

shouldn't be signed. Each physician (or physician's corporation or partnership) must make that decision. The informed physician's personal attorney and accountant must be consulted before decisions are made.

Your attorney has undoubtedly explained that when you are considering an Individual Participation Agreement with an HMO, PPO or IPA you may not band together with other physicians to negotiate the contract collectively, because that violates antitrust laws. You can, however, individually negotiate your own contract by yourself or with your personal attorney or financial advisor. ◀

Judee Gallagher, J.D., is a Chicago private practice attorney retained by the ISMS Office of Contractual Services since 1985.

Dx: recurrent herpes labialis



"HERPECIN-L is my **treatment of choice** for perioral herpes." GP, NY

"HERPECIN-L appears to actually **prevent** the blisters . . . used **soon enough**." DDS, MN

"HERPECIN-L . . . a **conservative approach** with **low risk/high benefits**." MD, FL

"Used at **prodromal symptoms** . . . blisters **never formed** . . . remarkable." DH, MA

"(In clinical trials) . . . **response was dramatic**. HERPECIN-L . . . **proven far superior**." DDS, PA

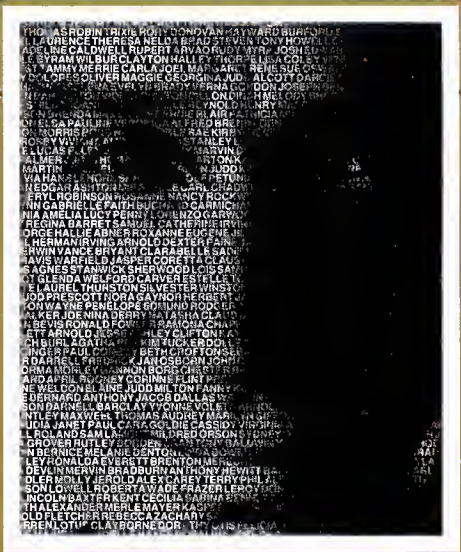
"All patients claimed **shorter duration** . . . at **prodromal symptoms** . . . HERPECIN-L **averted the attacks**." MD, AK

OTC. See P.D.R. for information. For samples to make your own clinical evaluation, write: CAMPBELL LABORATORIES, INC., P.O. BOX 812-MD, FDR STATION, NEW YORK, N.Y. 10150

In Illinois HERPECIN-L is available at all *Osco, Revco, SuperRx and Walgreens* and other select pharmacies.

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In a recent survey, 4,120 participating physicians gave us their views¹ on **INDERAL LA** in the treatment of hypertension, angina and migraine.

INDERAL LA is their preferred beta blocker

...of the nearly three out of four physicians responding to the questionnaire, an impressive 97% rated **INDERAL LA** good to excellent for overall performance. Virtually all cited efficacy, tolerability, long-term cardiovascular protection and once-daily convenience as important factors in their choosing to prescribe **INDERAL LA**.

INDERAL LA promotes patient compliance

...Virtually every responding physician rated patient satisfaction with **INDERAL LA** to be as good as, or better than, other beta blockers.

Like conventional **INDERAL** Tablets, **INDERAL LA** should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree and bronchial asthma.

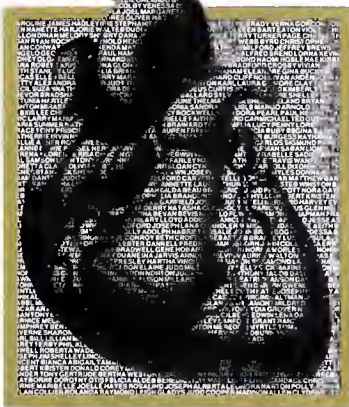
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INDERAL® LA
 (PROPRANOLOL HCl) LONG ACTING CAPSULES
 60, 80, 120, 160 mg

The one you know best keeps looking better

Please see next page for brief summary of prescribing information.

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 L BILL LILLIAN MARLE
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 S MEREDITH ALEXAND
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ONCE-DAILY
INDERAL LA
(PROPRANOLOL HCl)
LONG ACTING
CAPSULES
60, 80, 120, 160 mg

The one you know best
keeps looking better



60 mg 80 mg 120 mg 160 mg

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL® LA brand of propranolol hydrochloride (Long Acting Capsules)

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. Inderal is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by Inderal, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

Inderal LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with Inderal LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of Inderal Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

Inderal LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to Inderal LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, Inderal LA has been therapeutically equivalent to the same mg dose of conventional Inderal as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. Inderal LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. **Hypertension:** Inderal LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. Inderal LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: Inderal LA is indicated for the long-term management of patients with angina pectoris.

Migraine: Inderal LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: Inderal LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. Inderal LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. Inderal is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with Inderal.

WARNINGS. **CARDIAC FAILURE:** Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or Inderal should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of Inderal therapy. Therefore, when discontinuance of Inderal is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. Inderal should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Inderal (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3 , and decreasing T_3 .

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. Inderal (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that Inderal may interfere with the glaucoma screening test. Withdrawal may lead to a return or increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if Inderal (propranolol HCl) is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbitone, and rifampin accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and lidocaine have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. Inderal has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. Inderal should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: Inderal is excreted in human milk. Caution should be exercised when Inderal is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasisiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. Inderal LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from Inderal Tablets to Inderal LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. Inderal LA should not be considered a simple mg-for-mg substitute for Inderal. Inderal LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 80 mg Inderal LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—Dosage must be individualized. Starting with 80 mg Inderal LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—Dosage must be individualized. The initial oral dose is 80 mg Inderal LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, Inderal LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg Inderal LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Reference:

1. Data on file, Ayerst Laboratories.

D7295/188

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OBITUARIES

****Anderson, Kenning M.**, Wilmette, died June 28, 1987 at the age of 84. Dr. Anderson was a 1929 graduate of the University of Illinois College of Medicine, Chicago.

***Boles, Donald J.**, Chicago, died December 16, 1987 at the age of 70. Dr. Boles was a 1939 graduate of the Loyola University Stritch School of Medicine, Maywood.

***Bryan, Fred M.**, Harvard, died December 11, 1987 at the age of 81. Dr. Bryan was a 1933 graduate of the Northwestern University Medical School, Chicago.

****Cannon, Herbert F.**, Antioch, died November 16, 1987 at the age of 93. Dr. Cannon was a 1926 graduate of the Northwestern University Medical School, Chicago.

****Chamberlain, Danford O.**, Chicago, died October 8, 1987 at the age of 82. Dr. Chamberlain was a 1930 graduate of the University of Vermont College of Medicine, Burlington.

Dominguez, Serafin M., Chicago, died June 18, 1987 at the age of 67. Dr. Dominguez was a 1948 graduate of the Universidad de la Habana, Facultad de Ciencias, Escuela de Medicina y Estomatologia, Havana, Cuba.

***Egen, William A.**, Wilmette, died August 4, 1987 at the age of 32. Dr. Egen was a 1981 graduate of the Northwestern University Medical School, Chicago.

****Golden, Jacob S.**, Chicago, died December 17, 1987 at the age of 85. Dr. Golden was a 1929 graduate of Rush Medical College, Chicago.

****Hoffman, Morris J.**, Oak Park, died December 21, 1987 at the age of 82. Dr. Hoffman was a 1928 graduate of the Loyola University Stritch School of Medicine, Maywood.

****Jensen, Anton M.**, River Forest, died December 6, 1987 at the age of 95. Dr. Jensen was a 1922 graduate of Det Laegevidenskabelige Fakultet Kobenhavns Universitet, Kobenhavn, Denmark.

***Julian, Ormand C.**, San Rafael, California, died December 18, 1987 at the age of 74. Dr. Julian was a 1937 graduate of the University of Chicago Pritzker School of Medicine, Chicago.

****Karp, George A.**, Evanston, died December 7, 1987 at the age of 85. Dr. Karp was a 1931 graduate of the Medizinische Fakultät der Universität Innsbruck, Innsbruck, Austria.

***Kroll, George**, Chicago, died November 23, 1987 at the age of 65. Dr. Kroll was a 1952 graduate of the University of Illinois College of Medicine, Chicago.

***Lyman, Homer, C.**, Normal, died December 7, 1987 at the age of 66. Dr. Lyman was a 1945 graduate of the University of Illinois College of Medicine, Chicago.

***Mulliken, Wallace D.**, Elgin, died November 24, 1987 at the age of 61. Dr. Mulliken was a 1954 graduate of the University of Illinois College of Medicine, Chicago.

***Pierce, James D.**, Skokie, died December 2, 1987 at the age of 73. Dr. Pierce was a 1940 graduate of the University of Illinois College of Medicine, Chicago.

Radywyl, Alexander, Wilmette, died May 30, 1987 at the age of 83. Dr. Radywyl was a 1931 graduate of the Universität Jana Kazimierza Wydział Lekarski Lwow, Austria.

****Satz, Leo A.**, Chicago, died June 26, 1987 at the age of 83. Dr. Satz was a 1932 graduate of the Universität Wien, Medizinische Fakultät, Vienna, Austria.

***Schiffbauer, William C.**, Streator, died December 9, 1987 at the age of 62. Dr. Schiffbauer was a 1953 graduate of Northwestern University Medical School, Chicago.

****Simon, Arthur C.**, Decatur, died December 11, 1987 at the age of 87. Dr. Simon was a 1926 graduate of the St. Louis University School of Medicine, St. Louis, Missouri.

Standish, Philip M., Bloomington, died June 16, 1987 at the age of 75. Dr. Standish was a 1936 graduate of the State University of New York Upstate College of Medicine, Syracuse.

***Stitzel, Wilbur L.**, Dixon, died June 22, 1987 at the age of 76. Dr. Stitzel was a 1948 graduate of the University of Health Sciences/The Chicago Medical School, Chicago.

****Warnik, Edward G.**, Chicago, died December 15, 1987 at the age of 82. Dr. Warnik was a 1937 graduate of the Loyola University Stritch School of Medicine, Maywood.

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**BRIEF SUMMARY (FOR FULL PRESCRIBING
INFORMATION, SEE PACKAGE INSERT)**

INDICATIONS AND USAGE

This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS

Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure

WARNINGS

In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring. In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class. Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS

Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued. Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS

Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.

Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur.

DOSE AND ADMINISTRATION

Therapy should be initiated with application of one Transderm-Nitro 5 mg/24 hr system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.

The usual dosage is one Transderm-Nitro 5 mg/24 hr system. Some patients, however, may require the Transderm-Nitro 10 mg/24 hr system. If a single Transderm-Nitro 5 mg/24 hr system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 mg/24 hr systems or one Transderm-Nitro 10 mg/24 hr system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 mg/24 hr system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone. The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs. Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS

A patient leaflet is supplied with the systems

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C I B A

Voting Is the Least You Can Do!

Upcoming Primary Election Signals the Start of 1988 Races

By GEORGE T. WILKINS, JR., M.D., EDWARDSVILLE
CHAIRMAN, ILLINOIS STATE MEDICAL SOCIETY
POLITICAL ACTION COMMITTEE

One vote determined that English rather than German would be the language of the United States. On March 15 and November 8, 1988, each voter can make a crucial difference by determining who will represent Illinois citizens in the General Assembly as well as in the Congress and White House.

The future of your medical practice and our health care system is in the hands of our elected officials. We must elect those individuals who share our position so that we can pass legislation promoting our views and forestall government activities which would hinder ISMS objectives.

Winners of most elections are determined by the content and impact of messages they send to the voters. To accomplish this they must rely on the generosity and active participation of their supporters. The medical community can be an important political support group.

We were not successful in enacting a cap on awards for noneconomic losses in medical malpractice

cases last year. Had the issue come to a vote we might have mustered 55 of the 60 votes required in the House and perhaps 27 or 28 of the 30 required votes in the Senate. In 1989 when we attempt to pass this legislation again we must make sure that the five or six additional votes in the House and the two or three additional votes in the Senate are there. The only realistic way to do this is to help elect candidates who support caps, and work against those who do not.

1. We must identify those races where there is a clear choice between the candidates in terms of their position on medical issues.
2. The medical community must pull together all of its

resources to give maximum support to the ideal candidate.

3. IMPAC must be able to play a major role in closely contested races, whether or not significant local medical resources are available.

Let's take a closer look at these three key elements:

First, we must identify those candidates who share our positions on the issues. The best way to accomplish this is to meet with declared candidates to assess their positions. Incumbents may be familiar with these issues while new candidates will have to be educated. Either way, this meeting provides an opportunity to share your concerns with the candidates and to seek to guide their eventual approach on legislative matters.

Many of you have met with your legislators several times over the past three years and know their positions. Don't let that stop you from meeting with them again. The more visibility, the better. Our professional liability initiatives have enabled Illinois physicians to form

solid relationships with legislators. Election years are an excellent time to further these relationships.

Second, local physician and auxiliary leadership must pull together the entire medical community in support of the candidate. The first thing to do may be to form a physician support committee that will see that all medical families are educated and involved. This committee should also interface with the candidate's campaign committee to coordinate a role for medicine in the overall campaign. At a minimum, fundraising and volunteer recruitment will be needed. Members of the medical community should serve on the candidate's finance committee and other committees formed within the campaign to perform a specific function. Members on these committees may then interact with the medical community. Some candidates may not have such a formal structure to their campaign. If not, remember that we want to contribute in any way that we can.

Third among the key elements, but perhaps the most important, is the Illinois State Medical Society Political Action Committee. Since 1960, IMPAC has played a deciding role in many campaigns because, unlike other PACs, we have been willing and able to provide candidates with the resources required for success. Many candidates have neither the know-how nor the resources to wage an effective campaign. In many instances, IMPAC has stepped in to fill this void. These

racers are costly, but we can ill afford not to do it.

In recent years we have witnessed the increasing activity of various groups, whether they be consumer groups, unions or business groups in legislative health care matters. Consumer groups and unions have stood opposed to our efforts to cap awards for noneconomic losses in medical malpractice cases. Business groups have pushed for legislation to cut health care costs, often without regard for the consequences to quality of care.

If we are to be successful in the chambers of the House and Senate we must identify those candidates who share our position on these issues and then see to it that they have the resources to succeed on election day. You can be sure that the groups who support such things as mandatory assignment and oppose caps on awards for noneconomic losses will be doing the same.

You can provide this support by contributing to IMPAC. Unlike a single contribution that may go unnoticed, IMPAC contributions—the total of all our contributions—constitute a major political force.

Our level of participation in the electoral process, both in number and dollar amount, must increase in order for us to remain a viable force in Springfield. So, participate!

Please send your questions, comments and ideas to the Government Affairs Division in our Chicago headquarters. ◀

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders; short-term relief of anxiety symptoms, acute alcohol withdrawal symptoms, preoperative apprehension and anxiety. Usually not required for anxiety or tension associated with stress of everyday life. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported after abrupt cessation of extended use of excessive doses are similar to those seen with barbiturates. Milder symptoms reported infrequently when continuous therapy is abruptly ended. Avoid abrupt discontinuation; gradually taper dosage.

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety disorders and symptoms, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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IDPH Issues Emergency Rules

Physician Responsibilities Under New AIDS Laws

As noted in the "Springfield Memo" column appearing in this issue, the Illinois Department of Public Health (IDPH) has adopted emergency rules for physicians and others who are affected by the new laws dealing with HIV antibody testing procedures. The rules affect a variety of clinical situations where the HIV antibody testing will occur. ISMS worked closely with the Department in developing the emergency rules, to ensure that they would incorporate the physician's perspective and needs in providing quality patient care. Public hearings on these and additional rules to implement the new AIDS laws will be held during the month of February. Individual physicians are encouraged to contact the Department if they would like to comment on these rules.

Emergency rules have been issued by the Illinois Department of Public Health (IDPH) governing clinical and laboratory conduct under the 1987 AIDS legislation. They fall into several broad categories: testing, informed consent, confidentiality, blood and tissue donors, and data collection.

Testing for HIV Antibodies

The emergency rules require that every blood sample obtained to determine the HIV antibody status of a patient be tested with the ELISA test. If the ELISA is found reactive, then a second ELISA must be conducted. If the second ELISA is also reactive, then a confirmatory test (Western blot assay or Indirect Fluorescent Antibody tests) must be conducted. If the sample is found to be positive on a confirmatory test, the sample shall be considered to indicate the presence of HIV

antibodies.

HIV Pre-Test Information

The physician must give the patient certain information before ordering an HIV antibody test. The information may be provided by the physician or a person delegated by the physician who is knowledgeable about HIV infection, including possible medical and psychological aspects of infection.

The pre-test information to be provided to the patient must include facts on: 1) The meaning of the test results (such as, its purpose, potential uses, and limitations of the test and its results); 2) The availability of additional or confirmatory testing (*i.e.*, Western blot); and 3) If appropriate, the availability of referrals for further information or counseling. Patients can be referred to IDPH Alternative Test Sites for post-test counseling.

Physicians may wish to consult the ISMS packet, "AIDS: Facts for Physicians," which was sent to all members, and review the insert titled, "Counseling Patients About AIDS," which provides this type of information.

The physician is not required to provide pre-test information to patients who: 1) Are research subjects, where the identity of the subject is not known and the researcher cannot retrieve that information, and the test subject is not informed of the results of the testing; or 2) Apply for insurance or HMO coverage where the HMO or insurer requires an HIV test.

Written Informed Consent

Physicians must obtain a patient's written, informed consent prior to ordering an HIV antibody test in most situations. The written consent may be obtained by the physician ordering the test or by another physician involved in the patient's care. The consent should be retained in the patient's medical record. The task of obtaining the consent may be done by the physician or by a person delegated this task who is knowledgeable about HIV infection, including possible medical and psychosocial aspects of infection.

Written, informed consent is not required for patients who: 1) Apply for marriage licenses; 2) Donate

organs, blood, plasma, human tissue or semen; 3) Are research subjects, and the identity of the patient is not known and may not be retrieved by the researcher and the test subject is not informed of the test results; 4) Are required by federal law to be tested (*i.e.*, immigrants); or 5) Apply for HMO or insurance coverage, when the HMO or insurer requires such testing for coverage.

IDPH has developed a sample consent form (Figure 1) for physician use. It may be copied or modified as appropriate.

Anonymous Testing

Patients have the right, except in specific circumstances listed below, to ask that the HIV antibody test be performed in a way that does not link their identity with the result of the test. If requested, the physician is to assign to the patient a unique number or notation to be used by the person to sign the consent form in lieu of the person's name. The blood sample for testing shall be labeled with the physician's name and the unique number or notation so the results are transmitted to the proper physician and given to the correct patient.

Anonymous testing is not permitted when: 1) Identification of the patient is permitted or required by law; 2) The test is conducted to satisfy the requirements of a marriage application; or 3) The test is performed to determine eligibility as a donor of blood, plasma, semen or other human tissue.

Disclosure of Test Results or Subject Identity

The following persons may be informed of the identity of a person tested or the results of such a test:

1. The patient who was the test subject, or that patient's legally authorized representative;
2. Any person designated in a release signed by the patient or the patient's representative;
3. Referring, treating or consulting physicians of the patient or an authorized agent or employee of a health facility or health care provider, if the facility or provider has authority to obtain the

Figure 1

Sample IDPH Written Consent for HIV Antibody Testing

Test Subject or Number: _____ Date: _____ Time: _____

I am giving my permission for a blood test in order to detect whether I have antibodies to the HIV (Human Immunodeficiency Virus) or any other identified causative agent of AIDS in my blood. I understand that the test results will be utilized for the purposes of my medical care and treatment.

I understand that the test is performed by withdrawing a sample of my blood and conducting laboratory tests to determine the presence of antibodies to HIV. I understand that the results of the blood tests considered to be positive will be reported to the Illinois Department of Public Health.

I further understand that a positive result does not mean I have AIDS, but that my blood has been exposed to the AIDS virus and antibodies to that virus are present in my blood. I understand that counseling concerning AIDS will be offered to me if my test results are found to be positive.

I have been informed and understand that the test results, in a percentage of cases, may indicate that a person has antibodies to the virus when the person does not have the antibodies (a false positive result) or that the test may fail to detect that a person has antibodies to the virus when the person does in fact have these antibodies (a false negative result).

I understand that my test results will be released to my physicians and other health care providers providing my care. In addition, I understand that the law allows my identity and test results to be disclosed to specific persons, such as the physicians and health care providers involved in the use of any donated organs or tissue, and the Illinois Department of Public Health, health care facility staff committees and research studies (without name). I understand that my test results will be kept confidential to the extent provided by law. I understand further that upon my request and when permitted by law, my written consent and test result will be coded so as not to connect the written consent form and the test results. In addition, I understand that I may withdraw from the testing at any point in time, prior to the completion of laboratory tests.

My physician has advised me about the purpose, potential issues, limitations and meaning of the test results; the voluntary nature of the test; the right to withdraw at any time prior to the completion of laboratory tests; the right to anonymity; and the confidentiality protections under the law. With the information presented above having been completely and clearly explained to me and all my questions having been answered, I hereby authorize _____ to test my blood for HIV infection.

Signature or Notation of
the Test Subject

Signature of Physician

test results and the agent or employee provides patient care or handles or processes specimens of body fluids or tissues and the agent or employee has a need to know this information in order to meet the medical needs of the patient;

- 4. IDPH, or local health departments, who are required by law to receive certain types of reports for controlling the spread of disease;
- 5. A health facility or provider which procures, processes, distributes or uses donated organs or semen;
- 6. Health facility staff committees, for the purposes of conducting program monitoring, evaluation or service reviews;
- 7. A person allowed by court order to have access; or
- 8. A county clerk, who is to be informed, via a physician's certificate, that parties to a marriage have received HIV antibody tests and been notified of the results of those tests. The clerk is *not* to receive the results of the tests.

In addition, HIV antibody test

results may be disclosed to health care providers and researchers when done in a manner which does not reveal the identity of the patient.

Persons are free from civil liability when disclosures are made in accordance with the law. However, intentional or reckless violation of the identity of the patient or test results constitutes a Class B misdemeanor.

Marriage License Testing Requirements

Within 30 days of applying for a marriage license, applicants must submit to a medical examination by a physician, which includes lab tests to determine the existence of or freedom from transmissible syphilis and exposure to HIV or any other identified causative agent of AIDS. The parties to the marriage may be examined by the same physician or separate physicians for each party. The exam can be conducted by a physician licensed in any state, upon certification that the doctor is licensed in that state.

The physician is to: 1) Provide the pre-test information to the parties (as described above); 2) Upon the patient's request, label the

blood sample for the HIV and syphilis tests in such a manner as to conceal the identity of the patient(s); 3) Use the approved testing procedure (described above); and 4) Give the results of the tests to both parties of the marriage. The physician is not required to perform the tests.

The results of the HIV antibody tests shall be provided by the physician(s) who administered the tests to both parties to the proposed marriage. If the test results are negative, the required notification need not be done in person. However, if one or both of the test results are confirmed as positive, the physician must present the results to both parties in person. Prior to signing and presenting the marriage certificate, the physician must provide them with information regarding the meaning of the results and the availability of further testing and counseling.

Figure 2 is a representative copy of the IDPH sample certificate, which has been designed for physician use and may be modified as appropriate. In addition, the IDPH has created a brochure on the requirements for marriage license applicants which physicians can obtain from county clerks or local health departments.

Again, the physician may wish to consult the ISMS publication "Counseling Patients About AIDS," prior to conducting the counseling. Patients can also be referred to an IDPH Alternative Test Site center for counseling.

Physicians are to report to IDPH or their local health department the results of any confirmed positive HIV antibody test of a marriage license applicant. The report is not to include the patient's name. It is to include other information about the subject:

- 1. City of residence;
- 2. Age;
- 3. Race/ethnicity;
- 4. Lab findings;
- 5. Risk factors;
- 6. Whether the patient is known to have previously tested positive for HIV antibodies;
- 7. If the test was conducted in compliance with the marriage license requirements; and
- 8. If counseling and/or sex part-

Figure 2

Sample IDPH Certificate of Marriage License Testing

Patient Name _____ Date: _____

I, (name of physician) being a physician legally licensed to practice in the state of _____ do certify that I did on the _____ day of _____ 19__ make an examination of _____ (patient's name) and considered the result of an approved serological test for syphilis, which was made at my request, and believe that (patient's name) may enter into marriage without danger of transmitting syphilis to the other party or to any issue of such marriage. My examination also included the approved tests for the presence of HIV infection as required by law. I have provided the results of the testing and the required information concerning the results to _____ and _____, who are parties to this proposed marriage.

(Signature of Physician)
or a legally authorized representative

(Signature of Patient)

ner referral has taken place, or if assistance is needed from the health department.

HIV Testing for Insurance Purposes

HMOs, insurance companies, health services corporations and other insurers subject to regulation under the Illinois Insurance Code, and physicians who perform HIV antibody tests for such insurers, are not subject to the laws dealing with pre-test counseling, written informed consent prior to testing, offering anonymous testing, or limitations on disclosure of test results for patients applying for new or additional coverage.

However, if an HMO or insurer requires an HIV antibody test for applicants for new or continued coverage, the HMO or insurer must: 1) Give the patient/applicant prior written notice of the testing requirement; 2) Obtain the written authorization of the patient/applicant to have the physician perform the tests; and 3) Keep the results of the tests confidential.

Notice of an adverse underwriting or coverage decision may be given to any interested party by the HMO or insurer, but the insurer may only disclose the test result itself to a physician designated by the applicant or patient, and any such disclosure shall be in a manner that assures confidentiality.

Enforcement of the Confidentiality Provisions

Physicians and other licensed providers who fail to comply with the confidentiality provisions of the AIDS laws shall be considered to have violated their licensure laws, and are subject to disciplinary action by the Department of Professional Regulation. In addition, the intentional or reckless violation of these rules constitutes a Class B misdemeanor.

HIV Testing for Blood and Human Tissue Donation

All potential donors of blood, plasma, organs, semen or other tissue, other than those donating under the Uniform Anatomical Gift Act, must be tested for HIV infection. Potential donors are to receive the required HIV pre-test informa-

Summary 1986 - 1991 Estimates	
<div>1. 1,000,000 - 1,500,000 Americans infected with HIV.</div> <div>2. 10 - 30% of infected persons have been diagnosed with AIDS after 5 year followup.</div> <div>3. 270,000 cases of AIDS will be diagnosed and reported by the end of 1991, 74,000 in 1991 alone.</div> <div>4. Direct costs of medical care for reported cases of AIDS for 1991: \$8,000,000,000.</div>	
AIDS - 1991 - United States Projected Cases and Medical Costs	
Cases diagnosed during year	74,000
Alive at start of year	71,000
Underreporting / Underascertainment	29,000
Requiring medical care during year	174,000
Deaths during year	54,000
Direct costs - per patient	(\$46,000)
Total	\$8,000,000,000

(Reprinted with permission of the Centers for Disease Control, Atlanta, Georgia)

tion and given the opportunity to refuse the test. Written informed consent is not required. If the person refuses the test, the person shall not be accepted as a donor.

AIDS Registry and Information

IDPH will create an AIDS registry to compile statistical data on treatment and prevention measures. Information shall not be released unless it is in statistical, non-identifiable form. Information may be released only to a local health department or registry in another state, and then only when it

concerns a person residing in that jurisdiction. There are additional rules on research requests and release of information to researchers.

Conclusion

IMJ will continue to provide updates on implementation of the AIDS legislation as available. Additional clinical information and resources are included in the ISMS information packet, "AIDS: Facts for Physicians," which has been sent to all members. Packets are available on request from the ISMS headquarters office.

ISMS Positions on AIDS and HIV Antibody Testing

The following positions on AIDS and HIV antibody testing issues were adopted by the Illinois State Medical Society's Board of Trustees on November 6, 1987 and January 30, 1988.

AIDS Research

ISMS should support continued research into the causes, prevention and treatment of AIDS and AIDS-related conditions.

Blood Donations and Aids

All individuals engaged in high risk behavior should voluntarily disqualify themselves as donors of blood and other tissues.

ISMS should assist physicians to educate their patients that donating blood does not expose the donor to the risk of AIDS.

"Designated blood donations" are an inappropriate means of dealing with the AIDS problem and inordinately tie up blood supplies. Designated or directed donations have not been shown to be safer than volunteer blood donations and could lead to directed donors withholding information that would exclude them.

Children With AIDS, ARC, or HIV Infection and School Policy

Since children with AIDS, ARC, or HIV infection do not pose a

recognized health risk to other children in the classroom setting, ISMS supports the right of these children to continue to attend school. However, a physician should determine whether attendance would endanger the health of a child with AIDS or ARC in those schools where certain communicable diseases are present. CDC guidelines for children with AIDS, ARC, or HIV infection should be followed.

In order to protect the privacy of a school-age child with AIDS, ARC, or HIV infection, the identity of such a child should be limited to a minimum number of school administration officials.

Confidentiality of Patients with AIDS and HIV Infection

The privacy of patients infected with the HIV virus should be protected.

Counseling Patients about AIDS and HIV Infection

Physicians should incorporate into their practices standard procedures for taking complete sexual

and lifestyle histories of their patients and should assume responsibility for educating their high-risk patients about the need to modify behavior which places the patients at risk for HIV infection.

Disclosing HIV Antibody Test Results

ISMS supports the sharing of information about the HIV antibody status of a patient with those physicians and health personnel who have a need to know such information due to their involvement in the patient's care. Such personnel must recognize their responsibility to maintain that information in compliance with state law governing the confidentiality of this and other patient information.

Educating Physicians and Other Health Professionals about AIDS and HIV Infection

Upon request, ISMS should provide information to its members on the many issues, legislation and developments related to AIDS,

including information on resources and specialists available to AIDS patients so the physician can educate himself and others about the disease and the HIV virus, and the limited mechanism by which the virus is or can be transmitted.

The ISMS Ad Hoc committee on AIDS will review legislation and make recommendations on issues as they develop.

ISMS encourages education and training of hospital medical staffs, nurses, other allied health personnel, and non-medical personnel in appropriate infection control procedures and preventing the transmission of the HIV virus, in order to protect hospital personnel and to reduce their anxieties and fears about contracting HIV infection, AIDS, or ARC.

Educating the Public About AIDS and HIV Infection

Education and counseling on transmission of the HIV and about AIDS to members of high risk groups and the general public is the only viable and effective means currently available to halt the spread of the disease.

ISMS should develop public position statements and encourage physicians to educate their patients and communities, consistent with current medical data, pertaining to public health issues of preventing the transmission of AIDS in all population groups.

ISMS should periodically release information to all Illinois media encouraging the people of Illinois to institute preventive education programs designed to reach all segments of society, with particular emphasis on teens and young adults.

ISMS supports efforts to provide education and training for public school employees on the transmission of the HIV virus and basic infection control and handling of blood or body fluids.

ISMS supports the teaching of information about AIDS within the school health curriculum, provided that community standards are taken into account during the development of this curriculum. Education for children about AIDS and transmission of the HIV virus is of primary importance in controlling the

spread of AIDS and HIV infection.

Physicians in local communities should be available to serve as a resource to schools to assist in these educational activities.

HIV Antibody Testing-General

Great public concern has been expressed over the past several years regarding the spread of AIDS. In response to this, it has become popular to want to use HIV antibody testing as a means to identify infected individuals in order to reduce the spread of this deadly disease. However, it must be noted that the HIV is spread largely through participation in certain high risk behaviors, and while a number of population groups have been termed "high risk," any individual involved in high risk behaviors can contract the HIV. Therefore, the mass testing of groups or individuals without reference to their behavior is medically inappropriate.

Testing for the HIV antibody should be used only in situations which benefit individual patients and the public health.

HIV Antibody Testing for Hospital Patients

ISMS opposes mandatory HIV testing of hospital patients since most patients would be discharged before a confirmatory test could be concluded. In addition, there would be a high false positive rate which could stigmatize patients and place unnecessary fear in the staff.

ISMS supports the position that all hospital patients be handled as though they are HIV positive and that hospitals, along with their medical staffs, develop methods of implementing CDC guidelines for the prevention of transmission of the HIV in the workplace and during invasive procedures.

HIV Antibody Testing for Marriage License Applicants

ISMS recognizes that HIV antibody testing of applicants for marriage licenses may have a limited value as a means of preventing and controlling HIV infection. However, physicians must, by law, counsel marriage license applicants, especially those who participate in high-

risk behavior, regarding AIDS, ARC and the transmission of HIV.

ISMS supports the distribution of informational material on AIDS, ARC and HIV infection to physicians and to couples applying for a marriage license and encourages the Illinois Department of Public Health to make such materials available.

Physicians should report to marriage license applicants who are the subject of an HIV antibody test, only negative ELISA results, or positive results of a Western blot or other confirmatory test. Positive ELISA results which have not been confirmed should not be reported to patients, since non-confirmed results could confuse and cause unnecessary concern by patients.

HIV Antibody Testing for Prisoners

ISMS supports the concept of voluntary, anonymous HIV testing for inmates in prisons and jails, with the results of such testing kept confidential. Counseling for those requesting such a test should be provided.

ISMS does not support the concept of mandatory HIV testing for inmates in prisons and jails. Education of prison inmates and staff regarding the transmission of the HIV should be conducted.

Look-Back Campaigns

ISMS supports the concept of "look-back" as a means of protecting patients and reducing the possible spread of disease. When a physician is notified that one of his/her patients has received blood from a donor who is now known as being Western blot positive, the doctor should:

1. Promptly notify the patient of the need to visit the office to discuss a medical condition;
2. Advise the patient in a confidential and personal fashion of the situation;
3. Offer to perform an HIV antibody test; and
4. Be prepared to provide the patient with social-psychiatric support and referral to an

infectious disease specialist.

In conjunction with their hospitals and local blood centers, medical staffs should develop policies and procedures for determining which physicians should be contacted about a patient who received such blood and who should be responsible for notifying the patient.

Information related to Western blot positive donors and patients who received blood from such donors should be strictly confidential and maintained as such by all individuals privileged to such information.

Physicians with AIDS, ARC, or HIV Infection

ISMS supports the position that

disclosure of the HIV status of a physician to a patient is an integral part of the physician/patient relationship and should be handled at that level.

Physicians who are HIV positive or who have ARC or AIDS should not be restricted from the practice of medicine provided that current CDC guidelines are followed and the health of the physician or the patient is not endangered.

Quarantine and Isolation of Patients with AIDS or HIV Infection

The quarantine and isolation of people with AIDS, ARC, or HIV infection is not at this time a necessary or effective means of control-

ling the spread of AIDS. However, quarantine and isolation may be necessary on a case-by-case basis in order to protect the public health.

Counseling and educational efforts, rather than policies promoting physical restriction and isolation, are appropriate primary methods for controlling the spread of AIDS and HIV infections, until further information suggests otherwise.

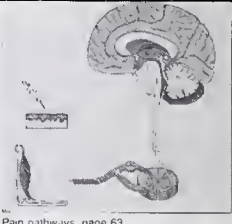

Treating AIDS Patients

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For Brief Summary, please see following page.

DURICEF® (CEFADROXIL)

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INDICATIONS: DURICEF (cefadroxil) is indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms: Urinary tract infections caused by *E. coli*, *P. mirabilis*, and *Klebsiella* species. Skin and skin structure infections caused by staphylococci and/or streptococci. Pharyngitis and tonsillitis caused by Group A beta-hemolytic streptococci. (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. DURICEF is generally effective in the eradication of streptococci from the nasopharynx; however, substantial data establishing the efficacy of DURICEF in the subsequent prevention of rheumatic fever are not available at present.)

Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

CONTRAINDICATIONS: DURICEF is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

WARNING: IN PENICILLIN-ALLERGIC PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF PENICILLINS AND CEPHALOSPORINS, AND THERE ARE INSTANCES OF PATIENTS WHO HAVE HAD REACTIONS TO BOTH DRUGS (INCLUDING FATAL ANAPHYLAXIS AFTER PARENTERAL USE).

Any patient who has demonstrated a history of some form of allergy, particularly to drugs, should receive antibiotics cautiously and then only when absolutely necessary. No exception should be made with regard to DURICEF (cefadroxil). **Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use.** Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Moderate to severe cases should be managed with fluid, electrolyte and protein supplementation as indicated. When the colitis is not relieved by drug discontinuance or when it is severe, oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should also be considered.

PRECAUTIONS: Patients should be followed carefully so that any side-effects or unusual manifestations of drug idiosyncrasy may be detected. If a hypersensitivity reaction occurs, the drug should be discontinued and the patient treated with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

DURICEF (cefadroxil) should be used with caution in the presence of markedly impaired renal function (creatinine clearance rate of less than 50 mL/min/1.73M²). (See Dosage and Administration section of Prescribing Information.) In patients with known or suspected renal impairment, careful clinical observation and appropriate laboratory studies should be made prior to and during therapy.

Prolonged use of DURICEF may result in the overgrowth of non-susceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug. DURICEF should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to 11 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cefadroxil. There are, however, no adequate and well controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Caution should be exercised when cefadroxil is administered to a nursing mother.

ADVERSE REACTIONS: *Gastrointestinal*—Symptoms of pseudomembranous colitis can appear during antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity—Allergies (in the form of rash, urticaria, and angioedema) have been observed. These reactions usually subsided upon discontinuation of the drug.

Other reactions have included genital pruritus, genital moniliasis, vaginitis, and moderate transient neutropenia.

Before prescribing or administering, see package insert

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Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

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Multi-specialty group needs the following physicians: Allergist, OB/GYN, Neurologist, Family Practitioner, Orthopedic Surgeon, V/T Surgeon, Dermatologist and Radiologist. Contact: Bill Harris, 2601 West Main, Carbondale 62901; (618) 549-5361. (12)

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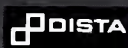
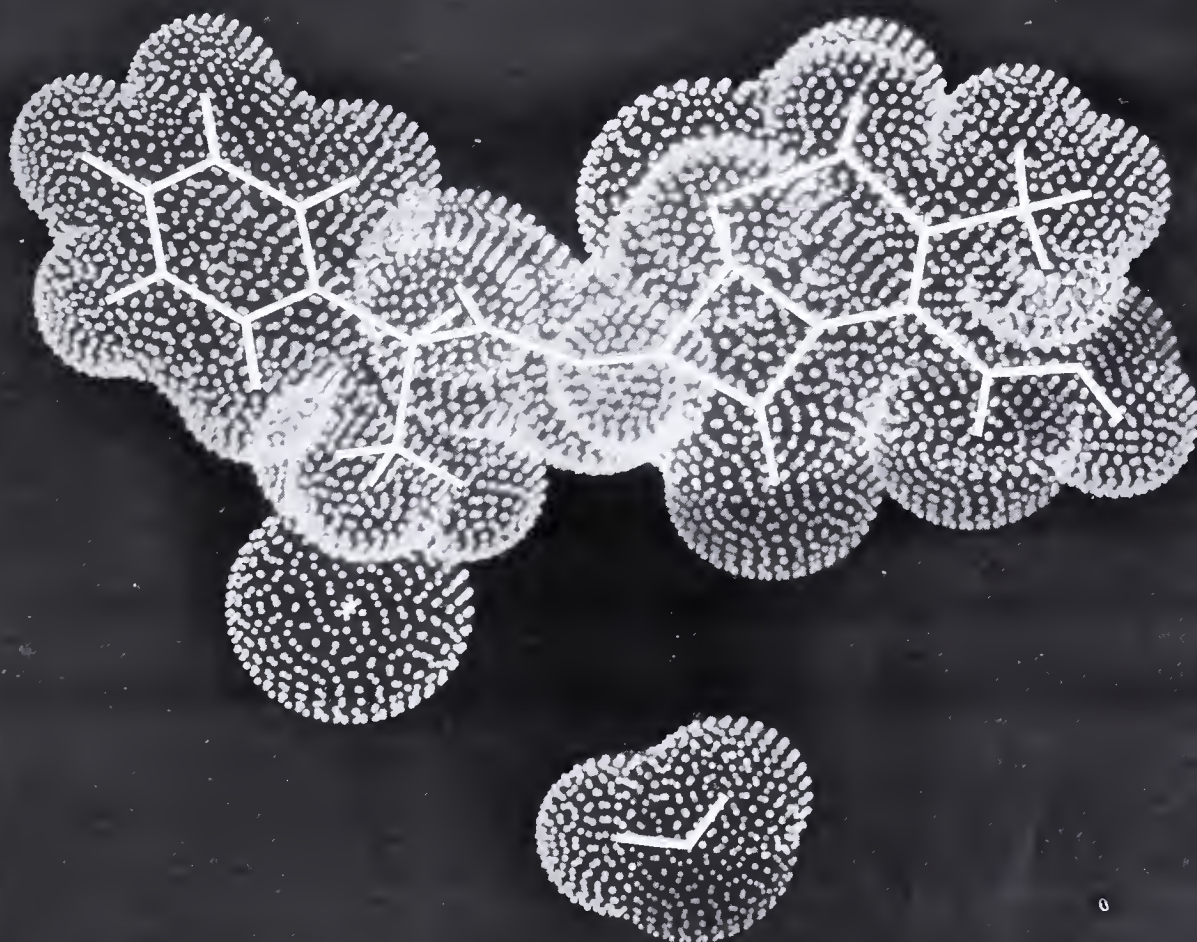
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Basic Principles in Management of Basal Cell Epithelioma

By PETER MCKINNEY, M.D., AND JUNE K. ROBINSON, M.D./CHICAGO

A basal cell epithelioma (BCE) is a tumor arising from the deepest cell of the epidermis—the basal cell. This cell is the germinal layer of the skin. It lies just above the dermis and is rectangular in shape, with a dark-staining nucleus. Its shape and color determine the “picket fence” or palisading appearance of the typical nodular basal cell epithelioma on microscopy.

This tumor, although technically classified as a skin cancer, rarely metastasizes, but may be locally destructive. For example, in one series of 100 consecutive cases, seven tumors involved the underlying facial bones.¹

In contrast, a recent study reported 141 patients with basal cell carcinoma who had undergone metastases.² In one larger series, one of 1,010 patients who presented with basal cell carcinoma developed a metastasis.¹ The criteria of Lattes and Kessler³ identifies such a metastasis: the tumor must arise from the skin, not the mucosa; it must have the identical histological features of the original tumor without any squamous cell component; and the metastasis must be at a

distance from the primary tumor. Most, *but not all*, of the patients who developed metastases had tumors greater than 10cm in diameter which had been present for many years. Many had been refractory to past treatment.⁴

The damage done by a BCE usually is confined to the local tissue. However, even a small tumor near the eye or nostril may be destructive and difficult to treat because of the difficulty in ascertaining adequate borders of the tumor.

Classification

Although the Armed Forces Institute of Pathology (AFIP) fascicle defines six histological types of basal cells,⁵ clinically most physicians define four types.⁶ The differentiation of these types of basal cells is useful in diagnosis and treatment. The cell types are:

1. *Nodulo-Ulcerative*

This most common form of basal cell epithelioma begins as a small translucent pearl in the skin with telangiectasias on the surface. As it outgrows its blood there is a central ulceration and umbilica-

tion or volcano appearance, with raised, pearly, well-circumscribed borders. (Figures 1A and B)

2. *Pigmented*

This is a variant of the nodulo-ulcerative form, with large amounts of melanin in the stroma of the tumor. (Figure 2A) Although it behaves like a nodulo-ulcerative BCE, the pigmented form is classified separately because of its color. (Figure 2B)

3. *Sclerosing*

Fortunately, this form is unusual, since the borders are vague or ill-defined and the tumor flat or somewhat depressed, giving the appearance of a patch of scar or a chicken pox mark. It lacks translucency and rolled margins. Microscopically, it is scattered throughout the section (Figure 3A) in branching thin strands embedded in dense fibrous stroma of collagen and elastic fibers. (Figure 3B) Palisading and stromal retraction are usually not seen.

4. *Superficial (field fire)*

This has the appearance of an

Figure 1



Figure 1A
Clinically the most common type, this nodular basal cell epithelioma demonstrates typical pearly translucent quality with overlying telangiectasia.

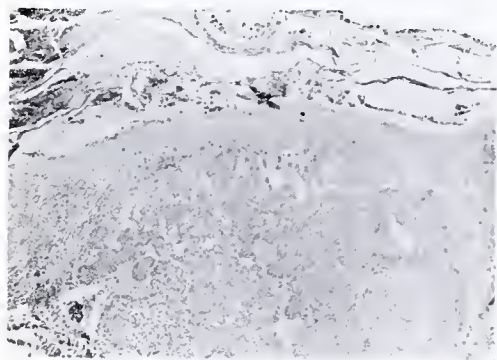


Figure 1B
Microscopically, masses of various shapes and sizes composed of basal cell epithelioma descend from the epidermis and fill the dermis. The peripheral cell layer of the tumor masses shows the palisade arrangement of the nuclei, the "picket-fence pattern."

Figure 2



Figure 2A
The pigmented basal cell epithelioma, a variant of the nodular type, behaves in a biologically similar manner. The central crusted ulcerated area accentuates the pearly borders in this case.

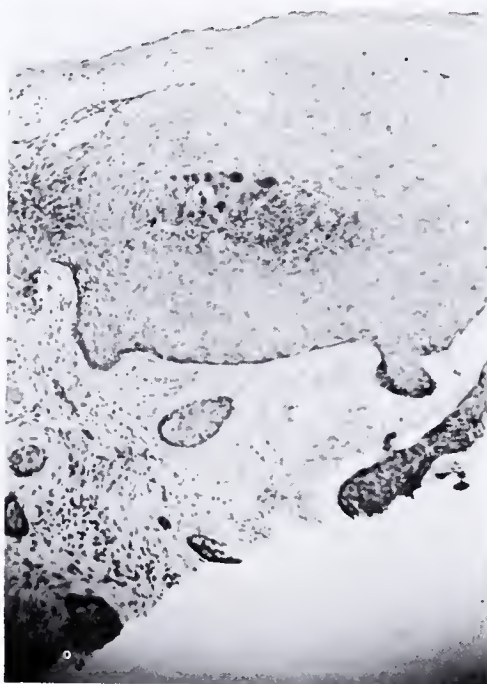


Figure 2B
In this example of a pigmented basal cell epithelioma, the melanin is concentrated in the center of a nest of basal cell epithelioma cells.

Figure 3



Figure 3A
An indurated yellowish plaque of morphea-like sclerosing basal cell epithelioma has an ill-defined border. The overlying skin rarely shows ulceration in this type.

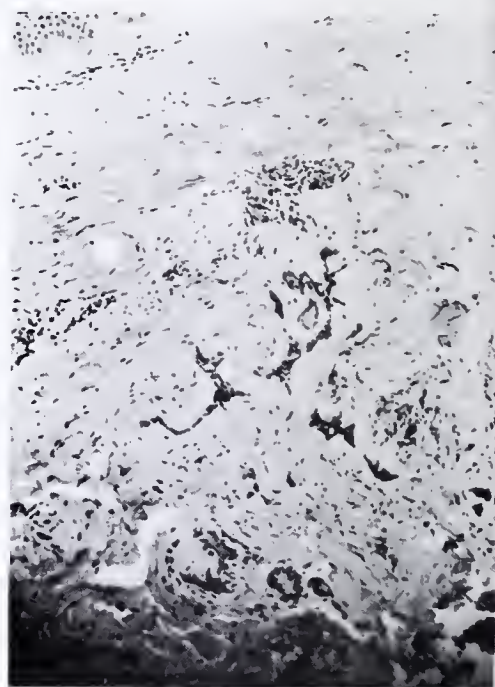


Figure 3B
Embedded in a dense fibrous stroma of the dermis, groups of closely packed tumor cells are arranged in elongated strands, which are often only one cell layer thick. The epidermis (top, left corner) rarely shows a connection with strands of tumor cells.

inflammatory crusting or scaling lesion, usually spreading at its periphery, then becoming invasive. It is generally found on the trunk. (Figure 4A) The margins have the pathologic appearance of a typical nodular BCE (Figure 4B), but the central portion resembles a scar, having a flattened and thinned epidermis, a

lack of adnexal structures, and thick horizontal collagen fibers in the dermis. Tumor cells are often absent in the center.

For therapeutic purposes, then, there are essentially two types of invasive BCE: those tumors with distinct, definable borders (nodular) and those with vague, ill-defined borders (sclerosing mor-

phea type). Histologically, the first type is seen with sharply circumscribed, almost capsulated borders, while the latter lesion has no beginning or end but is scattered throughout the microscopic field. The tumors may be multifocal or have many roots (Figure 5), but the effect is the same. The surgeon needs a wider margin, and the

Figure 4

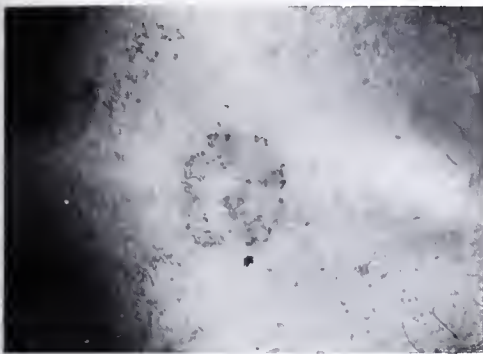


Figure 4A
A solitary erythematous, scaling, slightly infiltrated patch on the chest is a superficial basal cell epithelioma, which occurs predominantly on the trunk. Although the center shows atrophic scarring, the patch has a fine, threadlike, pearly border.



Figure 4B
The superficial basal cell epithelioma shows a bud of irregularly proliferating tumor tissue attached to the undersurface of the epidermis.

chance of recurrence is greater because of the scattered edge.

Location and Prevalence

A basal cell tumor arises more commonly in a fair complexioned Caucasian in areas of the body exposed to sunlight. Typically, a red-haired, pale-skinned, freckled individual living in a tropical cli-

mate is very prone to the disease. In northern climates,⁵ 95% of the tumors are seen on the head and neck compared to only 75% in tropical regions, where the limbs are more exposed to sunlight. Men are twice as likely to develop the disease as women, presumably because of their greater exposure to sunlight.⁷ In the United States, in people over 40 the tumor prevalence is 3/1,000.⁸ The lesion is extremely rare in blacks and Orientals, occurring in them almost exclusively in conjunction with other skin disease.⁹

Differential Diagnosis

It should be possible to diagnose 96.5% of basal cell carcinomas clinically.⁵ A nodular BCE with a volcano appearance, the rim waxy and covered with a few telangiectasias, may occasionally be confused with a fibroma, a trichoepithelioma, or sebaceous hyperplasia. The other varieties, however, may be more subtle in appearance. A pigmented BCE may be confused with a melanoma, nevus, or dermatofibroma. Sclerosing BCE may be similar to xanthelasma, sebaceous adenoma, ostoma cutis, morphea or an old flat scar.

When any doubt exists, a biopsy should be done prior to treatment. If the lesion is small enough, an excisional biopsy may also provide the correct treatment.

Etiology

Ultraviolet Radiation

Basal cell carcinoma is a disease caused by exposure to sunlight.¹ The wavelengths from 230 to 320 μ m alter the mitotic and DNA activity in the skin and are carcinogenic. People living in sunny regions are the most likely group to develop this tumor on the exposed portions of their body.¹⁰

X-ray

Approximately 10% of patients with BCEs develop them because of prior radiation treatment, most often that given for acne or for hair removal.⁵ Fortunately, the deleterious effects of such radiation treatments have been recognized, and they are rarely used today. However, patients previously treated will continue to develop the disease and

must be watched closely for the development of lesions.

Congenital

Certain congenital syndromes and skin lesions have a propensity for the development of basal cell carcinoma. These are:

1. Nevus sebaceous: This lesion is elevated above the skin and has a

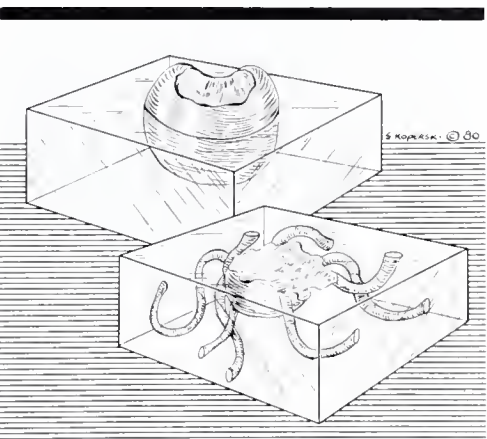


Figure 5
This drawing conceptualizes the basic differences amongst the various types of BCEs. The upper type has a sharp clean border and is basically easy to remove. The tumor in the lower drawing has multiple extensions, roots or new growths; it is these types that require a wide border.

verrucous appearance. There is a high incidence of BCE after puberty. Some series have reported up to 15% of lesions developing into BCE, most often nodular in type.⁶ (Figure 6)

2. Basal cell nevus syndrome: Persons with this inherited disease (autosomal dominant) have multiple BCE and jaw cysts with or without palm pits and calcification of falx cerebri. The basal cells are dormant during childhood but become very aggressive after puberty. They may be a mixture of superficial, nodular and sclerosing BCEs. (Figure 7)
3. Xeroderma pigmentosa. A sex-linked recessive gene causes increased sensitivity to sun (a defect in DNA repair) and is associated with elevated gamma globulin and serum copper in

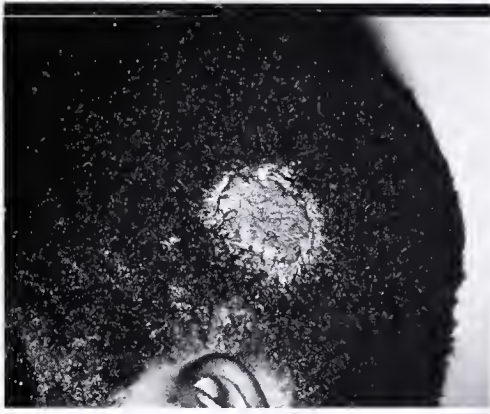


Figure 6
A raised, hairless plaque of nevus sebaceous developed a verrucous surface after the patient reached puberty. A basal cell epithelioma has been observed in 7% to 14% of cases of nevus sebaceous.



Figure 7
The multiple basal cell epitheliomas in the basal cell nevus syndrome present like any other type of basal cell carcinoma. They may become very invasive and destructive.

the blood.¹⁰ Skin freckles and telangiectasia are prominent; in later life squamous BCE and even melanoma may develop. (Figure 8)

Chemical

Trivalent arsenicals, either dietary or medicinal, can cause skin tumors, some of which are BCEs. They may occur on the back, arms or limbs, but rarely on the face.¹

Traumatic

Occasionally, tumors are seen in areas of chronic irritation, such as a burn scar.¹⁰ This type of tumor should not be confused with the squamous carcinoma that arises in chronic ulcers (so-called Marjolin's ulcer).^{1-8,10}

Immunosuppressive

There may be an increase in BCEs in patients undergoing renal transplants.¹⁰ What role immunosuppressive therapy plays in this increase is as yet unclear.

Treatment

Treatment must be individualized to the type of lesion, its location on the body, and the physical and emotional status of the patient. This means that physicians must have several treatment options at their disposal.



Figure 8
The diffuse erythema, atrophy of skin, telangiectases, and mottled pigmentation of this 25-year-old woman with xeroderma pigmentosum resemble changes of the skin seen in chronic radiodermatitis. The patient has undergone orbital exenteration for a malignant melanoma of the eye.

1. Curettage and electrodesiccation

This treatment works well for the superficial BCE or the small nodular type of tumor, which is soft and separates easily from surrounding tissue. It gives 95% cure,^{9,10} and is the method used to treat the majority of BCEs in this country, as most are seen by dermatologists.¹⁰ The method may fail if the lesion is near the eyelid or ala, where subsequent scar contracture causes distortion of the surrounding structures. In such cases surgical excision and repair are preferable. Curettage and electrodesiccation may also fail with the sclerosing (morphea) type of basal cell, because of its vague borders and lack of ready identification of tumor margins from the surrounding tissue. In addition, there is no histological section of the margins with the technique.

2. Superficial x-ray treatment

This is useful in patients with all varieties of basal cells and is advocated for difficult locations, such as the corner of the nose or the eyelid. Reported cures of 92.7% at five years and 88.9% at 10 years attest to its effectiveness.⁹ However, there is no histological control of the edges. Because of the chronic endarteritis induced by radiation, ongoing changes occur in the skin which can lead to the very disease being treated. With the advent of Mohs' "chemosurgery" (discussed later in this paper), the role of radiation has diminished and treatment is advised for very select patients, i.e., the infirm and the elderly. X-ray treatment is also not recommended for young patients and larger lesions are less successfully treated. For fields 10cm or greater in size, the recurrence rate following radiation treatment has been reported to be as high as 25%.¹⁰

3. 5 Fluorouracil (5 FU)

In 5% concentrations, 5 FU is useful for superficial lesions, such as keratosis and perhaps superficial BCEs. It is not useful for the nodular or invasive types

Figure 9



Figure 9A
Preoperative appearance of a recurrent basal cell carcinoma of the nose.



Figure 9B
Following Mohs' chemosurgery, the extent of the defect created by resection of the tumor includes loss of the nasal tip, the cartilagenous nasal septum and most of the right and left alae.



Figure 9C
A forehead flap covered the defect.



Figure 9D,E
The result at one year. The patient refused a prosthesis because of her difficulty in eyesight making it hard to use. In the author's experience, the nasal prosthesis does not stay on well for defects of this size.



excision is advisable. The theory, as with other chemotherapeutic agents, is that fluorouracil destroys the more active cells, preserving the normal. Higher concentrations of 5 FU are not any more effective. However, recurrences are frequent, and most clinicians are switching away from 5 FU to electrodesiccation and curettage.

4. Surgical excision

The mainstay of treatment for BCEs is surgical excision, as it gives control of the margins of the lesion (via frozen section) and allows repair if needed, which helps to avoid contractions. In nodular types of basal cells, the excision is simple and requires only a small margin, 2-3mm or less.¹¹ Repair can be undertaken immediately by either graft or flap. For the ill-defined border of the sclerosing BCE or for recurrent lesions, at least a 55mm border with frozen section control is needed. Cure rates have been reported at 98%.¹¹ The disadvantage of surgical excision is that it is considerably more expensive to the patient, since it requires both

of tumor.¹⁰ The patient applies the ointment BID for three weeks with a cotton tip applicator, limiting the application to the lesion only. This evokes an

inflammatory response, followed by an ulceration which heals spontaneously. If there is suspicion that the lesion is not completely removed, surgical

surgical time and some hospitalization. Surgery should, therefore, be reserved for treatment of the more complex lesions.

5. Mohs' chemosurgery

First described 40 years ago, this technique originally utilized a zinc paste to fix the tissue *in situ*. The tumor was then excised, with mapping of the sections removed, and frozen sections of the entire undersurface and lateral margins examined. When this fixed method of histologically-controlled excision of the lesion was used, deformities developed from the scar contractions, especially in vital areas. This led to a slow acceptance of the technique.

Since then, modification of the "fresh tissue" technique has been made, and the popularity of the treatment has increased without compromise to its effectiveness in removing tumors, which, even with difficult and recurrent lesions, approaches 99%.^{5,6,12} We believe the value lies in the pinpoint histological mapping of the tumor margins. This has particular value in sclerosing or recurrent lesions, particularly when certain anatomical structures must be preserved. The development of immunohistochemical staining of tumor cells has allowed greater accuracy in interpretation of the pathology.¹³ Accurate removal of the tumor allows for easier reconstruction by preserving the maximal amount of tissue. We have found, however, that flaps are more useful than grafts in patients undergoing immediate reconstruction.¹¹

In practice, patients who have (a) recurrent or sclerosing lesions and/or (b) lesions in locations that require tissue preservation, such as the vermillion border, the eyelid or the border of the nose, are treated on an outpatient basis with the excisional technique of Mohs. If the wound is simple, the patient returns home. If necessary, the wound is closed later in the day by a plastic surgery technique. The uni- or V-pucker flaps have

Figure 10



Figure 10A
Prior to Moh's treatment of a BCE.
Notice the other lesions.



Figure 10B
Post Moh's excision.



Figure 10C
A series of pucker flaps and a composite graft for the ala complete the closure.



Figure 10D
The result at six months.

been most useful, (Figure 9) but in more difficult situations, more complex flaps are required. (Figure 10) In some situations, instead of reconstruction, a prosthesis will suffice. If a graft is used, further excision of the cauterized base is necessary, as without it poor take of the grafts has been a common experience.

Summary

A basal cell epithelioma is a semi-malignant tumor of the exposed

portions of the body caused by sunlight in the majority of patients. It usually has low malignant potential except when neglected, and it rarely metastasizes. The aim of treatment for a BCE must be adequate removal of the lesion with an acceptable aesthetic result.¹ This can be accomplished in several ways:

1. *Nodular types.* Surgical excision gives the best control of the wound edges and results in the best reconstruction.
2. *Superficial types.* Cryosurgery or curettage and electrodesiccation

Figure 11



Figure 11A
A BCE at the vermilion.



Figure 11B
After Moh's excision a unilateral "pucker" flap is fashioned.



Figure 11C
The flap is advanced on its subcutaneous pedicle.



Figure 11D
The result at three months.

are recommended. If this treatment does not provide control, then excision is necessary.

3. *Sclerosing or morphea.* Mohs' chemosurgery provides the best control of borders and allows for immediate reconstruction if needed.
4. *Recurrent.* Mohs' chemosurgery is the treatment of choice.

The treatments discussed should give cure rates in excess of 98%. ◀

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From Apparently Healthy Infertile Women

Endocervical Culture Isolates

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Complications following hysterosalpyngograms, intrauterine manipulations and inseminations, or seemingly uncomplicated spontaneous abortions are not uncommon findings when evaluating infertile women. Metritis may occur following any one of the above conditions or spontaneously. Occasionally, empirical antibiotic treatment of these infertile patients results in improved fertility.¹⁻³

Many reports have studied the bacterial flora of the vagina and cervix,^{4,5} in addition to pelvic inflammatory disease,^{6,7} and cervicitis. Rarely are detailed studies performed in apparently healthy infertile women. This report describes the findings of routine endocervical cultures and antibiotic susceptibility of isolated aerobic and anaerobic bacteria from women consulting for infertility.

Bacterial cultures from the endocervical area in 540 consecutive infertile married women were performed. All patients were totally asymptomatic at the time of investigation. The specimens for bacterial culture were obtained from a clean cervix at the level of the internal os or fundus, as aseptically as possible at the peak of estrogenic activity.

Microbiological Procedures

To obtain aerobic cultures, selective plates were utilized for inoculation, such as tryptic soy agar with 5% sheep blood, phenylethyl alcohol agar, chocolate agar, modified Thayer-Martin agar, MacConkey, and fluid thioglycollate medium. All cultures were incubated at 37°C for 24 hours. If no growth was

observed during 24 hours, the cultures were reincubated for an additional 24 hour period.

Anaerobic cultures were obtained using selective plates such as CNA and KV sheep blood anaerobic agar. Enriched thioglycollate medium was used as a backup system. All inoculated plates, as well as enriched thioglycollate medium, were placed in a gas-pack jar with a gas-pack II generator envelope and indicator and were incubated at 37°C for 48 hours.

After incubation, and at varying periods thereafter, a sample of any colony growth present on agar plates was gram stained and microscopically examined for identification. In addition, antimicrobial susceptibility testing was performed.

The disk diffusion method⁸ was employed for aerobic susceptibility, and thioglycollate broth disc method⁹ was used for anaerobic susceptibility.

Results

No bacterial growth was observed in 269 (49.8%) endocervical cultures. One microorganism was recovered from the endocervical cultures of 175 (32.4%) patients, two types of microorganisms were found in 73 (13.5%), three types in 18 (3.5%), and four or more microorganisms were found in 5 (0.9%) cultures. Of the 271 positive endocervical cultures, aerobic bacteria only were isolated from 128 (47.2%) cultures. Anaerobic bacteria only were recovered from 103 (38.0%) cultures, while both types of bacteria were recovered from 40 (14.8%) cultures. Bacterial type and frequency are detailed in Tables 1 and 2. The most common aerobes identified were gram negative enterics such as *Escherichia coli* and gram positive cocci such as the *Streptococcus* and *Staphylococcus* species. The most common anaerobes identified were *Bacteroides*, *Streptococcus* and *Clostridium* species.

The *in vitro* susceptibility of the isolated organisms to various antibacterial agents is shown in Table 3.

Table 1
Frequency of Various Aerobic Bacteria Isolated in 271 Endocervical Cultures From Apparently Healthy Infertile Women

Isolates	Number	Percent
Gram-Positive Bacteria:		
<i>Staphylococcus epidermidis</i>	43	20.5
<i>Staphylococcus aureus</i>	1	0.5
<i>Micrococcus</i> species	2	1.0
Nonhaemolytic streptococci	4	1.9
Alfa haemolytic streptococci	10	4.8
Beta streptococcus not group A	2	1.0
Beta streptococcus group B	5	2.4
Group D enterococcus	28	13.3
Group D not enterococcus	1	0.5
<i>Streptococcus pneumoniae</i>	2	1.0
Yeast	24	11.4
Gram-Negative Bacteria:		
<i>Escherichia coli</i>	52	24.8
<i>Enterobacter</i> species	2	1.0
<i>Klebsiella</i> species	5	2.4
<i>Haemophilus</i> species	14	6.7
<i>Neisseria sicca</i>	1	0.5
Non Fermenters:		
<i>Acinetobacter lwoffii</i>	8	3.8
<i>Cardiobacterium hominis</i>	3	1.4
<i>Flavobacterium</i> species	1	0.5
<i>Pseudomonas</i> species	2	1.0

Table 2
Frequency of Various Anaerobic Bacteria Isolated in 271 Endocervical Cultures from Apparently Healthy Infertile Women

Isolates	Number	Percent
Gram-Positive Bacteria:		
<i>Peptococcus</i> species	10	5.2
<i>Peptostreptococcus</i> species	22	11.4
<i>Streptococcus intermedius</i>	3	1.6
<i>Gaffkya anaerobia</i>	4	2.1
<i>Actinomyces viscosus</i>	1	0.5
<i>Bifidobacterium</i> species	5	2.6
<i>Eubacterium</i> species	14	7.3
<i>Lactobacillus</i> species	22	11.4
<i>Clostridium</i> species	22	11.4
Gram-Negative Bacteria:		
<i>Acidaminococcus fermentans</i>	15	7.8
<i>Bacteroides</i> species	67	34.7
<i>Capnocytophaga ochraceus</i>	1	0.5
<i>Fusobacterium</i> species	7	3.6

Bacterial susceptibility was graded as sensitive or resistant. Chloramphenicol, cefoperazone, carbenicillin and ampicillin were effective against 80% or more of the bacteria cultured. Penicillin, tetracycline and clindamycin were less than 60% effective, while erythromycin and cephalothin were intermediate against the bacteria tested.

Discussion

In a 1951 study of the bacterial population in 100 sterile women Matthews and Buxton¹⁰ described the spermicidal effects of *Escherichia coli* and *Streptococcus viridans*. Since that time, the importance of studying bacteriology in women with infections other than those caused by gonococcus and chlamydia has become known.⁴⁻⁷

Laughton¹¹ reported that about half of 67 infertile women studied had pus in the cervix. In our study, although the culture specimens were obtained from a clean cervix, 73 (26.9%) women demonstrated a large number of leukocytes. Our investigation also revealed that previous pelvic infection did not necessarily preclude the presence of bacteria, since only 50 (18.5%) women reported a history of pelvic infection.

Corbishley⁵ described multibacterial cultures in 40 women (67%) with a marked history of promiscuity who were fitted for IUDs. Our patients, who had long-term marriages and no promiscuous history, showed a surprisingly elevated number of bacteria in the cultures—271 (50.2%) positive cultures—despite the fact that 73.1% showed no evidence of endocervical pathology (such as an increased number of leukocytes) at the time the sample was retrieved.

In view of these findings, we strongly believe that a culture taken at the level of the internal os and at the estrogenic peak, with proper asepsia, constitutes a valuable tool in the diagnosis of cryptic pathogenic bacterial populations in women consulting for infertility. The bacteria may cause an explosive pelvic infection in the higher genital tract during the course of intrauterine manipulations. The proper timing of the culture—at the estrogenic peak—is stressed because the

Table 3
In Vitro Antibacterial Susceptibility of the Aerobic and Anaerobic Bacteria Isolated from 271 Endocervical Cultures from Apparently Healthy Infertile Women

Antibacterial Agent	mcg	Aerobes		Anaerobes		Overall	
		Number of Susceptible Specimens	(%)	Number of Susceptible Specimens	(%)	Number of Susceptible Specimens	(%)
Chloramphenicol	30	154	84.4	127	85.8	281	85.1
Cefoperazone	75	62	69.4	47	100	109	82.6
Carbenicillin	100	59	61.0	59	100	118	80.5
Ampicillin	10	155	70.3	108	93.5	263	79.8
Cephalothin	30	152	53.3	121	80.2	273	65.2
Erythromycin	15	63	66.7	30	56.7	93	62.4
Clindamycin	2	33	42.4	28	71.4	61	55.7
Tetracycline	30	151	35.8	134	76.9	285	55.4
Penicillin	10 u	89	43.8	48	66.7	137	51.8

sampling is more easily obtained at this time due to the physiologic opening at the level of the internal os. It is also very important to perform antibiotic sensitivities, as the findings may be surprisingly unexpected. (Table 3) The more common antibiotics such as penicillin, tetracycline and erythromycin were less effective than chloramphenicol, cefoperazone, carbenicillin and ampicillin.

Conclusion

During the evaluation of infertile women, it is suggested that routine endocervical cultures be performed at the level of the internal os or fundus. Positive-culture patients should be treated, not empirically, but with appropriate antibiotics. It is further emphasized that a repeat endocervical culture be performed in women prior to any intrauterine manipulations.

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Congenital Cholesteatoma of the Middle Ear

By EDWARD S. TRAISMAN, M.D., TAWFIK F. GIRGIS, M.D., AND
HOWARD S. TRAISMAN, M.D./CHICAGO

Congenital cholesteatoma of the middle ear is an uncommon condition which may be detected on routine otoscopic exam or as the etiology of a conductive hearing loss. It is an epidermoid cyst located behind an intact tympanic membrane¹ without previous history of perforation or trauma to the involved tympanic membrane.^{2,3} Congenital cholesteatoma should be considered in the evaluation of conductive hearing loss or of a middle ear mass.

The patient had been healthy until age one, when he developed recurrent bouts of otitis media, which responded to appropriate antibiotic therapy. One such episode resulted in left tympanic membrane rupture and was healed with antibiotic treatment. Serous otitis media was noted at otoscopic exams. At age two, a tympanogram was performed and was flat bilaterally. The patient was referred for bilateral myringotomy. Otoscopic exam revealed a right middle ear cholesteatoma. CT scan of the petrous pyramids showed a right middle ear soft tissue mass; no bony erosion was noted. The right external auditory canal was normal. A right middle ear cholesteatoma was removed surgically. (Figure 1) The patient has done well subsequently.

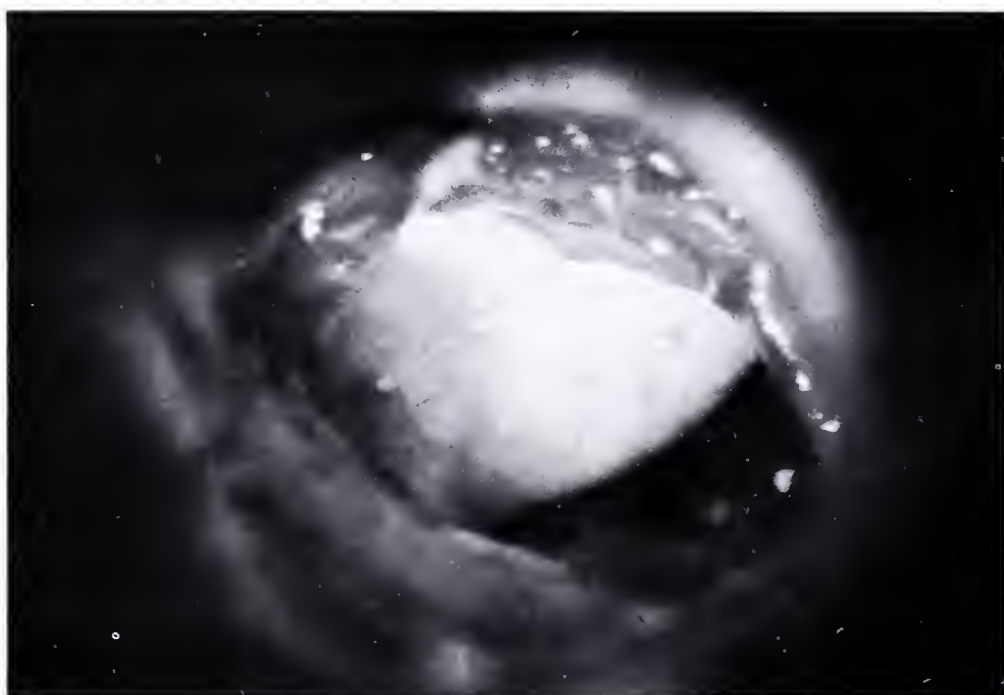


Figure 1
Tympanic membrane reflected forward exposes a well-encapsulated congenital cholesteatoma.

Discussion

Intracranial cholesteatoma was first described in 1829 by Cruveilhier as a "pearly tumor."¹ Muller, in 1838, called this tumor a cholesteatoma, as it contained cholestrin crystals.¹ On pathological exam, the cholesteatoma appears as an epidermoid cyst with stratified squamous epithelial cells over a connective tissue stroma which encapsulates desquamated epithelium, cholestrin crystals, and globules of fat.

Cholesteatoma may be acquired or congenital in origin. Acquired cholesteatoma results commonly from perforation of the tympanic membrane secondary to infection or trauma. Congenital cholesteatoma arises behind an intact tympanic membrane without history of previous aural infection, and consists of squamous epithelium of embryoid origin.² History of previous trauma or surgery to the tympanic membrane must be excluded.³

There are five sites of congenital cholesteatoma occurrence: (1) petrous apex; (2) mastoid; (3) middle ear; (4) both middle ear and mastoid; and (5) external canal.⁴ Clinical symptoms vary according to the location of the cholesteatoma. Petrous apex cholesteatoma usually presents with facial nerve paralysis or sensorineural hearing loss. Vertigo and nystagmus may be presenting signs and symptoms for congenital cholesteatoma.³ Mastoid and/or middle ear cholesteatoma present with conductive hearing loss.^{2,5} The majority of cases however, are detected by the physician during a routine exam not associated with a hearing deficit, and are observed as a white or golden mass behind an intact tympanic membrane. The use of pneu-mo-otoscopy with an air-

tight halogen-illuminated otoscope makes the tentative diagnosis of cholesteatoma. Special attention should be directed to the posterior superior quadrant of the tympanic membrane, where this lesion is usually located.⁶

Complete workup including otomicroscopy, audiometry, tympanometry and CT scanning of the temporal bones is of paramount importance to evaluate the extent of the cholesteatoma. Although the lesion is very slow growing, total extirpation by surgical means is indicated as treatment as soon as the lesion is diagnosed. In most instances, a single operation is sufficient. However, close observation and frequent examination is important, since these lesions have a tendency to recur.

We report a patient with congenital cholesteatoma to increase the physician's awareness of this entity. Cholesteatoma should be considered in the differential diagnosis of a child with persistent conductive hearing loss or a mass behind the tympanic membrane visible on otoscopic exam. ◀

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In Clinical Laboratory Procedures

Faculty Perceptions of Student Training

By RAYMOND L. OLESINSKI, M.H.P.E., LEWIS R. COULSON, M.D.,
AND ANNETTE M. YONKE, Ph.D./CHICAGO

This report presents the results of a survey of clerkship faculty, developed to determine their perceptions of student training in the performance of 15 pre-selected clinical laboratory procedures. A majority of the 71 respondents indicated that students should be taught to perform 13 of the procedures. A majority of faculty responded that they felt their students were capable of independent, correct performance for no procedure on entrance to, and for only three procedures on exit from the clerkship year. A significant percentage of faculty could not evaluate student performance. The estimated frequency of performance for each procedure is also reported.

The results of a survey of fourth-year medical students regarding their training in, and performance of, clinical laboratory procedures have been reported elsewhere.¹ A simultaneous survey of their clerkship faculty was conducted to assess their perceptions of student activity in this area. Both studies were undertaken with a twofold purpose: to serve as a basis for possible curriculum revision and to supply a uniquely detailed version of this area of student experience. Former reports concerning student performance of clinical laboratory procedures dealt with only single procedures,^{2,3} or grouped all performance into a single ill-defined category.^{4,5} This project sought to provide an expanded insight into this portion of the curriculum by gathering data about a large battery of procedures. This communication reports the findings of the faculty survey.

Methodology

Data were collected regarding fifteen preselected clinical laboratory procedures which a student could be expected to perform during a clerkship. The surveys were distributed in the spring of 1982 to 197 physicians having the rank of assistant professor or above from the departments of medicine, obstetrics/gynecology, pediatrics, and surgery. Faculty were instructed to respond only if they had been actively engaged in teaching clerkship students during the previous two years. They were also asked if they considered themselves to be primarily university or hospital salaried, or if they derived most of their income from private practice.

Results and Discussion

Seventy-one (39.7%) of the faculty members returned usable surveys; no data were included from private practitioners. The pertinent

findings are summarized in Table 1. Our opinion that the procedures selected for use in this study were representative of those that could be performed by students was supported by the fact that no additional procedures were added to the list by any of the respondents, although space was provided for that purpose.

While high percentages of faculty felt that students should be trained in each of these procedures, most procedures were estimated to be infrequently performed. This is contradictory to maintaining or improving competence in these skills after initial training. Considering that training in the performance of 11 of these procedures was a required instructional objective of our medical school, it does not appear that preclerkship instruction was adequate to meet the entry level skill requirements of the faculty. Although improvement was perceived in skill levels at the completion of the clerkship year, in all but three cases, greater than half of the faculty still felt that a majority of the students they taught were incapable of independent performance. The role that performance frequency may play in improving student skill level is underscored by the finding that, in all but two instances, the greatest improvement occurred for procedures per-

Table 1
 Summary of Clerkship Faculty Surveys of Perceptions of Student Training in the Performance of Clinical Laboratory Procedures*

Procedure	Students Should Be Taught	Skill Level				Frequency of Performance†
		Entrance to Clerkship Year		Exit from Clerkship Year		
		Independent Performance	Could not Evaluate	Independent Performance	Could not Evaluate	
Gram's stain	95.8	10.8	36.5	34.2	30.2	W
Stool for occult blood	92.9	24.7	37.0	52.7	33.8	D
Examination of peripheral blood smear	92.8	5.5	46.6	6.8	43.2	<M
Urine dipstick test	91.5	29.7	36.5	54.1	33.8	D
Hematocrit	91.5	27.0	35.1	50.7	32.0	D
Urine specific gravity	91.4	25.7	40.5	41.3	38.7	<M
Urine sediment examination	91.3	6.9	43.1	23.0	40.5	W
KOH stain for fungi	87.3	5.4	43.2	17.8	42.5	<M
Stool exam, color & consistency	85.7	23.3	43.8	41.9	39.2	<M
Inoculation of media	84.3	11.1	54.2	18.3	53.5	<M
Acid fast stain	78.6	4.1	46.6	16.7	42.5	<M
Stool exam, ova & parasites	75.4	2.8	52.8	6.8	59.5	<M
Body fluid cell count & differential	67.1	4.2	47.2	11.0	50.7	<M
Stool exam for fats	65.1	4.2	59.7	12.3	63.1	<M
India ink stain	56.7	4.2	63.4	8.1	66.2	<M

*Independent performance refers to the percentage of total respondents selecting the response: "The majority of students you taught could perform this procedure correctly without assistance." All numbers represent the percentage of total respondents; n = 71.
 †Most frequent response category: D = daily, W = weekly, <M = <1/month.

formed daily or weekly.

It should be emphasized that what constituted performance was left to the discretion of the respondents. It is quite possible that the students' actual skill levels, as measured by more objective standards of performance, would have differed from faculty estimates. Regardless, it appears that the faculty's responses indicate a satisfactory level of discrimination between those procedures which they felt their students could perform correctly without assistance and those that they could not.

The number of faculty who could not evaluate student performance is striking and perplexing. Perhaps more would have attempted to evaluate their students had a more objective instrument been used. However, it is also possible that close supervision by the faculty did not occur in many cases, or was

prohibited by the low rate of performance for most of the procedures, since more faculty members tended to evaluate students for procedures more frequently performed. Comments supplied with the returned surveys indicated that some respondents felt that the housestaff was perhaps the best group to evaluate student performance in these areas. Nevertheless, the fact that many of the faculty could not evaluate their students is consistent with one of the recognized problems of clinical education.⁶

The major question is whether or not the performance of clinical laboratory procedures by a medical student warrants a place in the curriculum. The findings presented here are consistent with those of other studies indicating that students do not spend much of their clerkship activity time on laboratory

work.^{1,4,5} If there is any advantage to be gained by training a student to personally perform a procedure, it may be lost through lack of skill retention due to infrequent opportunities for practice. In an era when competent clinical laboratories are readily available and physician office testing is assuming an increasingly significant role,⁷ it may be time to recognize that personal performance of all but a few clinical laboratory procedures by students should no longer be a requisite element of the medical school curriculum. Rather, it may be more beneficial to provide the future physician with the knowledge required to properly direct an office laboratory and the performance of these procedures by others.

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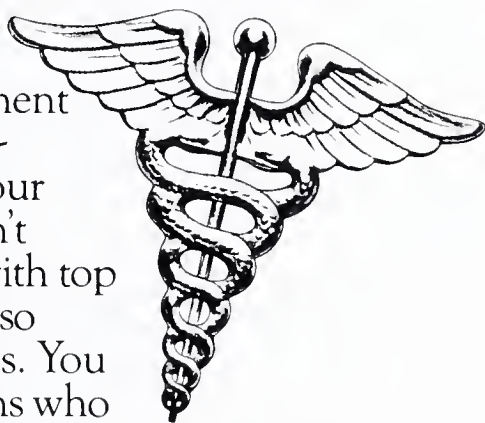
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Balloon Dilatation for Aortic Stenosis

BY TED E. FELDMAN, M.D., Y. CHRISTOPHER CHIU, M.D., AND JOHN D. CARROLL, M.D./CHICAGO

Catheter balloon valvuloplasty is a new technique for the treatment of critical cardiac valvular stenosis in adult patients. Catheter dilatation may be performed in patients at high risk for surgical valve replacement, such as those with left ventricular failure or chronic lung disease. It has been employed successfully in patients with calcified valves without causing either embolization or valve insufficiency. We report a patient with aortic valve stenosis who illustrates important issues for case selection, and we describe the technique of percutaneous valvuloplasty.

Although surgical aortic valve replacement has been successful therapy for many patients with critical aortic valve stenosis, it is clear that some patients fall into a high risk group for surgery. Patients with left ventricular failure may have operative mortality as high as 10%-25%.^{1,2} Catheter balloon valvuloplasty is being developed as an alternative nonsurgical therapy for these patients.^{3,4}

We describe a patient who illustrates important aspects of case selection and the current state of the technique of aortic balloon valvuloplasty.

Case Report

The patient is a 62-year-old man who was apparently healthy until six months prior to presentation, when he developed progressive dyspnea on exertion and orthopnea. There was no chest pain or syncope. On physical examination blood pressure measured 110/80. The carotid pulse volume and upstroke were

diminished. There was a grade II/VI systolic ejection murmur and the second heart sound was single. Echocardiogram showed moderate to severe aortic valve stenosis with markedly reduced right and left ventricular function. Cardiac catheterization was performed using a fluid-filled catheter. Pressure recordings showed left ventricular and aortic pressures of 170/28 and 105/65 respectively. (Figure 1) The peak-to-peak gradient measured 65mmHg, the mean gradient 53mmHg, and the cardiac output 4.1L/minute (Fick method). This resulted in a calculated aortic valve area of 0.5 cm². No significant aortic regurgitation was seen on aortogram. Coronary arteriography revealed only mild disease of the left anterior descending coronary artery.

Balloon Dilatation

The patient gave written informed consent in accordance with a protocol approved by the clinical

investigation committee of our institution.

Valvular dilatation was accomplished using a 15mm diameter, 3 cm long balloon catheter, inserted from the femoral artery over a 220cm guidewire and passed retrograde across the aortic valve. (Figure 2) Multiple inflations of 2-5 atmospheres lasting 10-15 seconds were performed. Following dilations, the peak-to-peak pressure gradient measured 30mmHg, the mean gradient 29mmHg and the calculated valve area 0.9 cm². (Figure 1) Doppler echocardiography both before and after dilatation showed no significant aortic regurgitation.

Discussion

Catheter balloon valvuloplasty was initially applied in children with pulmonic valve stenosis.⁵ Young patients with rheumatic mitral and congenital aortic stenosis were treated shortly thereafter.^{6,7} Concern about embolization of valve fragments necessitated a deliberate approach to balloon dilatation of calcified valves in older patients. Early reports of successful valve dilatation have made it clear that the procedure can be performed with adequate safety in adult patients.^{3,4,8}

Results of Aortic Valvuloplasty

Aortic valve dilatation typically results in a 50% increase in valve

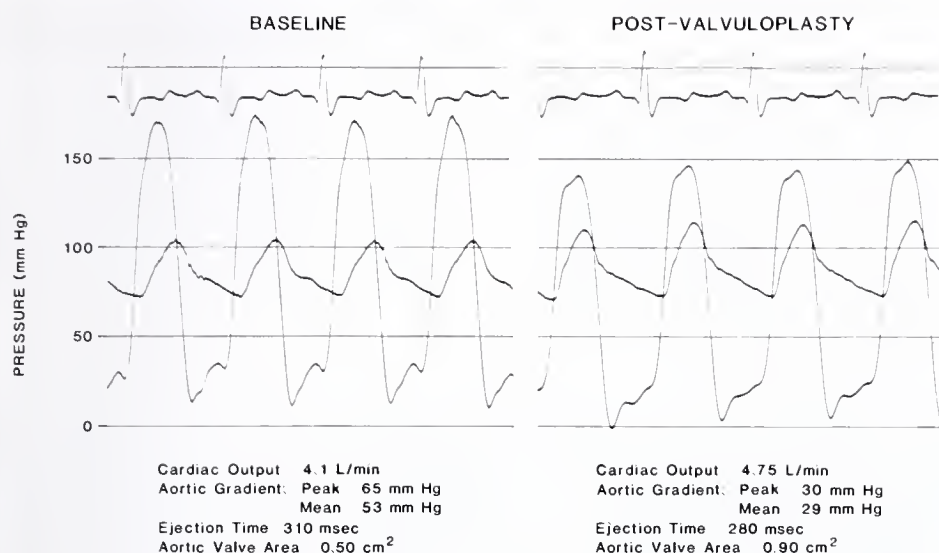


Figure 1
Simultaneous left ventricular and femoral arterial pressure recordings before and after catheter dilatation. The left ventricular pressure is high and the arterial pulse upstroke has marked delay prior to valvuloplasty. Afterwards, the left ventricular pressure falls, aortic pressure rises, and the peripheral arterial pressure upstroke is steeper. Valve area is increased by 80%.



Figure 2
Inflated balloon across the heavily calcified aortic valve (arrowhead). The balloon is indented by the stenotic valve orifice (arrow). The distal guidewire tip is curled in the left ventricular apex.

area, often with complete resolution of symptoms.⁸ The patient reported here is representative of our current experience in over 40 patients. Residual peak-to-peak transaortic valve gradients average 30-40mmHg, with a range between 10 and 75mmHg, depending on the initial gradient and the success of dilatation. Although the valve area is usually improved significantly, there is residual aortic stenosis of moderate degree. Usual average post-valvuloplasty valve areas are 0.9 to 1.0 cm². It is important to recognize that prosthetic heart valves have average functional areas between 1.1 and 1.8 cm². Left ventricular systolic performance improves after valve dilatation in many patients.

Two potential complications, induction of aortic insufficiency and embolization from the valve, have been infrequent. The risk of stroke and of death appears to be 1%-2%. Local femoral arterial complications are currently the major problem with performing the procedure, occurring in 10%-15% of patients. These are due to the large diameter of the deflated balloon catheter, which must be passed into the femoral artery. The development of lower profile catheters is already underway, and should reduce the incidence of vascular trauma.

Mechanism of Valve Dilatation

Postmortem and intraoperative valvuloplasty has been performed to elucidate the mechanism of valve area improvement.³ In specimens with commissural fusion, balloon dilatation results in separation of leaflets along fused commissures. There has been no evidence of tearing of leaflets or disruption of the valve annulus as long as balloons of 20mm diameter or less are used. In addition, calcified nodules on the valve leaflets are fractured, resulting in increased leaflet mobility.

Patient Selection

Symptomatic patients with critical aortic valve stenosis who are high risk for surgery or who refuse surgical therapy are candidates for valvuloplasty. Patients with depressed left ventricular function, advanced age, prior bypass surgery,

chronic lung disease, obesity, renal failure, or bleeding diathesis, are at high risk for surgical therapy. The mean age of patients we have treated for aortic valve stenosis is 71 years, similar to that reported in other series.

The presence of coronary artery disease is not a contraindication to valve dilatation. In one recent series 28% of patients had significant coronary stenosis greater than 50% in at least one vessel, including 19% with three vessel or left main coronary disease.⁸ We have performed aortic valvuloplasty in eleven patients with coronary artery disease.

Clinical Implications

Aortic valvuloplasty may be accomplished safely and successfully in symptomatic patients with aortic stenosis. The procedure extends therapy to patients previously considered very high risk for surgery, and to those who refuse surgery or anticoagulant therapy. Development of the technique for mitral valve dilatation has similarly broadened the population for whom therapy is available. In addition, mitral valvuloplasty results in valve areas similar to those achieved with surgical commissurotomy, and may eventually offer an alternative to surgical therapy.

The long term results of aortic valvuloplasty are not known. With only slightly more than one year followup on the initial patients to undergo the procedure, there have

been instances of restenosis. Catheter balloon valvuloplasty remains a promising therapy. ◀

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Summary of Issues and Actions

AMA HMSS Tenth Assembly

About 50 Illinois HMSS representatives attended the AMA HMSS tenth assembly meeting immediately preceding the AMA Interim Meeting in Atlanta, Georgia. The Illinois Section held two morning caucuses to review proposed resolutions and discuss pertinent issues.

The AMA House of Delegates strongly supported an AMA HMSS resolution reaffirming the autonomy of the hospital medical staff. The resolution encourages hospital medical executive committees and their legal counsel to regularly examine hospital/corporate bylaws and other policies for conflicts with medical staff bylaws and policies. The resolution also requires that hospital governing bodies notify medical staffs of any impending changes in the hospital/corporate bylaws and how those changes will affect the medical staff bylaws.

In addition, the AMA approved a plan supported by the HMSS to enhance the role of the medical staff by developing guidelines for medical directors. The guidelines will help to strengthen the relationship between the medical staff and the medical director. The AMA opposes regulations that allow hos-

pital governing boards to appoint a medical director who has authority over the medical staff.

The AMA also backed the AMA HMSS resolution requesting that the AMA work with the Joint Commission on Accreditation of Healthcare Organizations to assure that appropriate members of the medical staff represent the medical staff during Joint Commission site surveys. The resolution also asks that both the medical staff designated support personnel and appropriate administrative staff participate in the Joint Commission survey.

Joseph L. Murphy, M.D., chairman, ISMS HMSS, has expressed special appreciation to the other Governing Council officers: Silvana Y. Menendez, M.D., vice chairman, Thomas C. Malvar, M.D., secretary, and George T. Wilkins, Jr., M.D., treasurer, and to Dennis M. Brown, M.D., John F. Schneider, M.D. and Raymond A. Dieter, Jr., M.D., who chaired the Resolution Review Committees and presented the resolutions to the Illinois Caucus.

The next AMA HMSS meeting will be held June 22-26, 1988 in Chicago, just prior to the AMA Annual Meeting.

Annual Meeting Scheduled for February 27, 1988

The third annual meeting of the Illinois Hospital Medical Staff Section, scheduled for Saturday, February 27, 1988, will provide pertinent information on an array of issues affecting the hospital medical staff. The Section will also hold its annual business session and elections.

Speakers will include Dennis O'Leary, M.D., president of the Joint Commission on Accreditation of Healthcare Organizations, who will describe the Joint Commission's new project entitled the "Agenda for Change." The goal of the project is to develop an outcome-oriented monitoring and evaluation process that will assist health care organizations in improving quality of care. Dr. O'Leary will explain the components of the new project, and the role the medical staff will play in its implementation.

Saul J. Morse, J.D., will discuss how hospital closings and mergings affect the medical staff. To what extent does the medical staff have input into hospital planning and governing board decisions? What actions can the medical staff take?

These are some of the questions he will address.

From the Governing Council of the American Medical Association's Hospital Medical Staff Section, Peter A. Duhamel, M.D., will summarize the national issues currently facing the AMA HMSS, and discuss the involvement of state hospital medical staff sections.

Lastly, two concurrent workshops will be offered. In the first workshop, "Effective Communicat- ing through the Media," partici- pants will learn how to prepare for and conduct an effective interview with the media. The second work- shop, "Negotiating your IPA, HMO

and PPO Contract," will be given by Judee Gallagher, J.D., counsel retained by ISMS for the Office of Contractual Services. This work- shop will help participants better understand the many facets associ- ated with contract medicine.

All Illinois hospital medical staff representatives and other interest- ed parties are invited to attend this important meeting. The meeting will be held at the ISMS Headquar- ters in Chicago at Twenty N. Michi- gan Avenue. For further informa- tion and to obtain a registration form, please call the ISMS HMSS at (312) 782-1654.

HMSS Eligibility Requirements

All Illinois medical staffs are urged to elect an HMSS representa- tive. Representatives must be ISMS members and have active clinical privileges. Representatives of the AMA HMSS are automatically members of the ISMS Section unless the medical staff decides oth- erwise. Each hospital may elect more than one representative, although only one will be eligible to vote. For more information regard- ing ISMS HMSS activities or mem- bership, please contact the ISMS HMSS. ◀

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The Fundraising Idea that Grew and Grew

By EVELYN PERLMUTTER (MRS. HAROLD),
AMA-ERF CHAIRMAN

Did your family get a holiday card this season with the names of physicians and their spouses from your county? If so, your local county auxiliary participates in the American Medical Association Education and Research Foundation (AMA-ERF) Holiday Sharing Card as a fundraiser. If not, perhaps this could be a future project of the Auxiliary in your county.

In 1959, Betty Ray of Chattanooga, Tennessee conceived the sharing card idea and, with the help of her fellow auxiliaries, contacted medical families and asked them to donate the money they would ordinarily spend on cards and postage to AMA-ERF. In exchange, the auxiliary would send a "sharing card" to all medical families listing the names of the donors. This project was so successful that it was subsequently shared with her state and at the AMA Auxiliary's Annual Convention. Betty (who is still active in auxiliary) could never have anticipated the impact the "sharing card" would make.

The sharing card continues to be popular, as each year more and more counties adopt it. Some auxiliaries have expanded the theme and are having Thanksgiving, Valentine, and "Doctor's Day" sharing cards.

Although the same concept that Betty Ray started is being followed, AMAA continues to promote the idea. An "AMA-ERF Handbook" is updated annually and gives complete instructions in starting a sharing card project. Included in the Handbook is the history of AMA-

ERF, a list of deans and medical school recipients with the amount received last year, promotional tools, press releases, sample letters, and more.

Sharing card contribution totals for 1987-1988 are not yet available, but last year over \$875,000 was made nationally. In Illinois, 11 of 28 counties participated in sharing

President's Note

If your county does not have an auxiliary to organize a "sharing card" or other health-related community project described in this column, perhaps you would like to inform your local county medical society of the following simple forms of membership available:

■ **Member-At-Large.** An individual who, through dues only (\$30 for AMAA and ISMSA), supports projects already in existence and provides seed money for the implementation of new ideas.

■ **Chartered membership.** Co-chairmen act as leadership contacts for AMAA and

ISMSA. The physician spouse group would be predominantly social, but could easily involve themselves in a worthy project (\$30 dues).

■ **Full membership involvement.** Involvement of multiple board members with attendance required at regular meetings. Dues would be \$30 plus an undetermined amount to support local auxiliary projects.

For further information please contact the ISMSA office at 312-782-2099.

Lynn Kassel (Mrs. Wayne),
ISMSA President

cards and brought in over \$18,000. As the state AMA-ERF chairman, all contributions come to me for checking, recording, and forwarding to AMAA. Currently, we are exceeding last year's figure.

Other Auxiliary AMA-ERF Projects

This is not to say that only sharing cards raise money. Some auxiliaries hold bazaars, raffles, boutiques, dinner-dances and sell Christmas cards, in addition to many other projects. Memorial Cards and Physician Courtesy Cards—to remember colleagues for professional courtesies—are other fundraising enterprises. The nature of the fundraising activity is dictated only by the imagination of the members.

Use of Contributions

Raising funds for AMA-ERF has

been the AMA Auxiliary's major national philanthropic endeavor for more than 34 years. Currently there are several funds in existence. The *Medical Excellence Fund* provides grants to medical schools for use as they see fit (i.e., building improvements, faculty salaries, library funds). The *Medical Student Assistance Fund* provides funds to medical schools for student financial aid. The *Development Fund* is used at the discretion of the AMA-ERF Board of Directors to support pilot and experimental health and medical programs. *Categorical Funds* are for specific research areas. The contributor can direct contributions to a desired medical school and a desired fund. If no designation is made, contributions go into a fund to be divided among all medical schools in the country. All contributions are tax deductible.

In Illinois, eleven medical

schools are listed in the AMA-ERF handbook as recipients of AMA-ERF contributions last year. Using one example, the University of Illinois College of Medicine has graduated 14,203 physicians and researchers. It annually receives over 2400 applications from prospective students who compete for the 331 places in each first-year class. The state legislature provides only 35 percent of the annual college of medicine budget and the remaining 65 percent must come from other sources.

Of the many worthy causes to which we can contribute, few can match the AMA-ERF in providing lasting and important benefits. By helping medical schools and medical students, we help to assure the high quality of medical education and care in our country. "Tomorrow's physicians need our help today."

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April—June, 1988

Geriatrics, 1988

March 28-April 1, 1988

Specialty Review in Radiology

April 4-8, 1988

Specialty Review in Obstetrics and Gynecology

April 17-23, 1988

Advances in Emergency Medicine, 1988

April 18-20, 1988

Modern Trauma Management

April 21-23, 1988

Advances in Surgery, 1988

April 25-29, 1988

Specialty Review in Urology

April 25-30, 1988

Specialty Review in Family Medicine

May 1-7, 1988

Specialty Review in Anesthesiology

May 15-20, 1988

Specialty Review in Orthopedic Surgery

May 22-28, 1988

Specialty Review in Pediatric Cardiology

June 1-4, 1988

Microneurosurgery of the Brain

June 2-6, 1988

Flexible Fiberoptic Sigmoidoscopy

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March

Clinical

44th Annual Midwest Clinical Conference

For: Physicians of all specialties. Conference, March 4-6, Palmer House, Chicago. **Sponsor:** Chicago Medical Society, 515 N. Dearborn, Chicago, IL 60610, and over 40 contributing specialties. **Fee:** Discounts for ISMS and CMS members. **Reg. Limit:** None. **Credit:** Category 1: 20 hours. **Contact:** Judy Beazley. **Phone:** (312) 670-2550 X 204.

Branch Day

For: Physicians of all specialties. Conference, March 3, Peoria Civic Center, Peoria, Illinois. **Sponsor:** St. Francis Medical Center, 530 N.E. Glen Oak, Peoria, IL 61637. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 5 hours. **Contact:** Bev Stear. **Phone:** (309) 655-2275.

Family Medicine

Perspectives in Primary Care

For: Primary care physicians and internists. Conference, March 25-26, Champaign, IL. **Sponsor:** University of Illinois College of Medicine-Urbana. **Fee:** \$165. **Reg. Limit:** 150. **Credit:** Category 1: 12.5 hours; AAFP Prescribed: 12.5 hours. **Contact:** James Leonard, M.D., 2011 Round Barn Road, Champaign, IL 61821. **Phone:** (217) 337-3322.

Hematology/Oncology/Internal Medicine

Advances in Autologous Bone Marrow Transplant

For: Hematologists, oncologists, and internists. Lecture, March 19, Marriott Oakbrook, Oak Brook, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** \$20. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Internal Medicine

Early Intervention in Acute Myocardial Infarction

For: Cardiologists and internists. Lecture, March 16, Holiday Plaza Complex, Matteson, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** \$65. **Reg. Limit:** 150. **Credit:** Category 1: 6 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Internal Medicine Review

For: Internists. Symposia, March 7-May 21, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** \$300. **Reg. Limit:** 225. **Credit:** Category 1: 36 hours; AAFP Prescribed: 36 hours; ADA: 36 hours. **Contact:** Loretta Giacometto. **Phone:** (800) 325-9862.

Ophthalmology

Fluorescein Angiography Workshop

For: Ophthalmologists. Workshop, March 11-12, Madison, WI. **Sponsor:** University of Wisconsin-Madison, CME 465B WARF Bldg., 610 Walnut Street, Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** 35. **Credit:** Category 1: 14 hours; other: University of Wisconsin CEUs: 14 hours. **Contact:** Cathy Means. **Phone:** (608) 263-6637.

Pathology

Neoplastic Lymph Node Pathology

For: Pathologists. Seminar, March 14, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Pathology Dept., Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644, and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours for Chicago Pathology Society members only. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5716.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or

Psychiatry

The Clinical Basis of Psychiatry

For: Psychiatrists and neurologists. Lecture, February 29-March 4, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** \$690. **Reg. Limit:** 90. **Credit:** Category 1: 44 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Radiology

Imaging Modalities in the Chest and Abdomen

For: Radiologists. Symposium, March 20-25, Maui, Hawaii. **Sponsor:** Loyola University Stritch School of Medicine, Division of CME, 2160 S. First Avenue, Maywood, IL 60153. **Fee:** \$485. **Reg. Limit:** 200. **Credit:** Category 1: 20 hours. **Contact:** Linda K. Gunzburger, Ph.D. **Phone:** (312) 531-3236.

Surgery

Specialty Review in General Surgery, Part II

For: General and specializing surgeons. Lecture, February 29-March 11, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** \$880. **Reg. Limit:** None. **Credit:** Category 1: 103 hours. **Contact:** Robert J. Baker, M.D. **Phone:** In Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

April

Allergy

Hypersensitivity to Penicillins and Cephalosporins

For: Interested physicians. Lecture, April 18, Holiday Inn, Chicago City Centre. **Sponsor:** Illinois Society of Allergy and Clinical Immunology, 800 E. Northwest Hwy., Suite 1080, Palatine, IL 60067. **Fee:** \$20 (dinner). **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** Diane Kubis. **Phone:** (312) 359-3090.

Cardiology

Eighth Annual Great Lakes Conference on High Blood Pressure

For: Interested physicians. Conference, April 18-20, Ann Arbor, MI. **Sponsors:** American Heart Association of Michigan, P.O. Box 160, Lathrup Village, MI 48076, and the Michigan Department of Public Health. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: To be determined. **Contact:** Tom Matz. **Phone:** (313) 557-9500.

Family Medicine/Gynecology

Geriatric Gynecology for the Primary Care Provider

For: Family practitioners and internists. Course, April 16, Merrillville, IN. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** \$25. **Reg. Limit:** 200. **Credit:** Category 1: 6 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Hematology/Oncology

Lymphoma 1988: New Diagnostic and Treatment Strategies

For: Interested physicians. Symposium, April 15, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** \$20. **Reg. Limit:** 200. **Credit:** Category 1: 6 hours; AAFP Prescribed: 6 hours; ADA: 6 hours. **Contact:** Loretta Giacometto. **Phone:** (800) 325-9862.

Internal Medicine/Family Medicine

Clinical Endocrinology '88

For: Internists and family practitioners. Lecture, April 9, Hyatt Regency Oakbrook, Oak Brook, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box

sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

139, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 6 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Neuroradiology

1988 Neuroradiology Review Course

For: General radiologists, neuroradiologists, neurosurgeons, neurologists, and residents. Course, April 30-May 1, Oakbrook Marriott Hotel, Oak Brook, IL. **Sponsors:** Loyola University Stritch School of Medicine, Dept. of CME and Department of Radiology, 2160 S. First Avenue, Maywood, IL 60153. **Fee:** \$170 for physicians, \$100 for residents. **Reg. Limit:** None. **Credit:** Category 1: 16 hours. **Contact:** Linda K. Gunzburger, Ph.D. **Phone:** (312) 531-3237.

Obstetrics/Gynecology

15th Annual Symposium on Obstetrics and Gynecology

For: Interested physicians. Symposium, April 28-29, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** \$200. **Reg. Limit:** 150. **Credit:** Category 1: 12 hours; AAFP Prescribed: 12 hours; ADA: 12 hours; ACOG cognates: 12 hours. **Contact:** Loretta Giacometto. **Phone:** (800) 325-9862.

Ophthalmology

Advanced Contact Lens Course

For: Ophthalmologists. Seminar, April 20-21, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** To be determined. **Reg. Limit:** 150. **Credit:** Category 1: 9 hours. **Contact:** Loretta Giacometto. **Phone:** (800) 325-9862.

Otolaryngology

Frontiers of Medicine: Recent Progress in Head and Neck Oncology

For: Otolaryngologists. Course, April 13, Chicago. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** 150. **Credit:** Category 1: 6 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Pathology

Future Trends in Evaluating Quality of Care

For: Pathologists. Lecture, April 11, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644, and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours for Chicago Pathology Society members only. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

Rehabilitation Medicine

Electromyography and Clinical Neurophysiology: A High Intensity Review

For: Electromyographers and senior residents. Course, April 4-7, Chicago, IL. **Sponsor:** Rehabilitation Institute of Chicago, 345 E. Superior Street, Ste. 1641, Chicago, IL 60611. **Fee:** \$425 for physicians; \$375 for residents. **Reg. Limit:** None. **Reg. Deadline:** March 20. **Credit:** Category 1: 21 hours. **Contact:** Ian MacLean, M.D. **Phone:** (312) 908-6098.

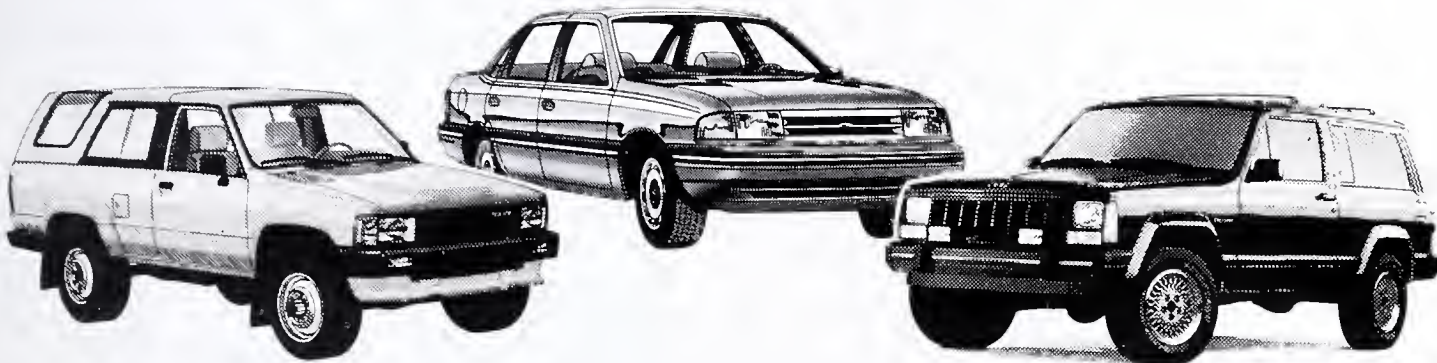
Urology

Frontiers in Endoscopy

For: Urologists. Workshop, April 15-16, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** To be determined. **Reg. Limit:** 80. **Credit:** Category 1: 11 hours. **Contact:** Loretta Giacometto. **Phone:** (800) 325-9862.

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

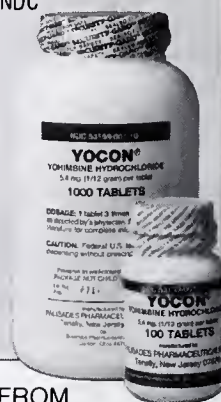
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
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4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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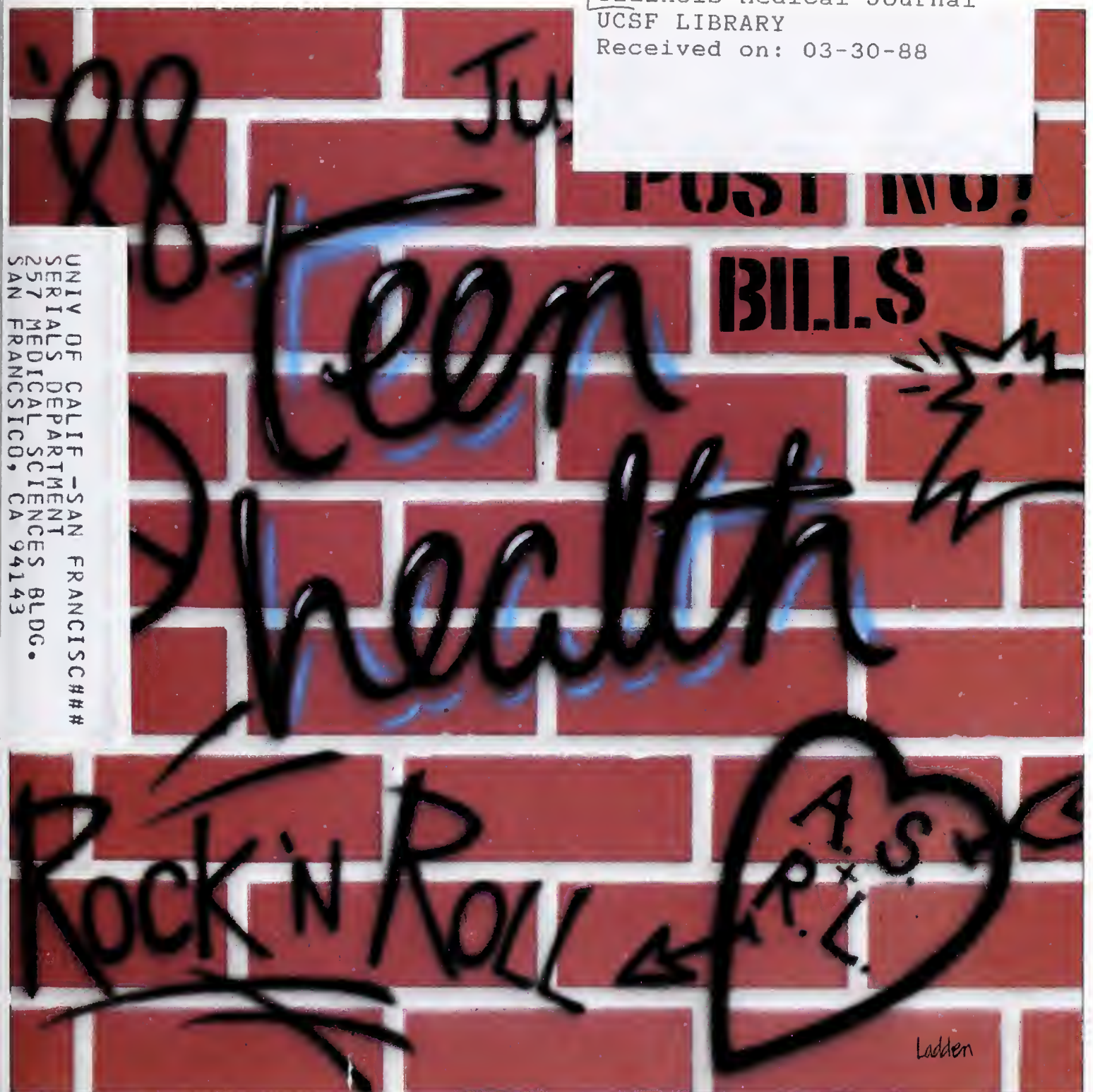
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Graffiti



Graffiti is exuberant frustration made visual. It is many other things as well. Graffiti is a destructive nuisance. It causes chagrin and disappointment, perhaps because it is so . . . *uncivilized*. It has been found scratched on Egyptian tombs and pyramids, Greek and Roman buildings and even in the catacombs. It covers a lot of New York City—especially buses and subways.

We have all done it as young

Driving too fast, drinking too much, jumping too far, doing “wheelies” and skating too near the edge of likely injury result in frequent violent death or injury.

How to help? Peer pressure is a potent means that teens themselves use to change behavior of their friends and each other. SADD (Students Against Drunk Driving) and In-Touch antidrug chapters in our high schools are examples of effec-

cannot achieve their goals and those of their parents and society is very frustrating. All of us place burdens on the backs of our children that many of them cannot bear. Let's help lighten them. Let children be children. When it's time to grow up, we must make sure that they have the knowledge to fulfill their responsibilities as adults and the sure conviction that if they do not, they must pay for it.

This issue takes a broad-brush approach, much like that our teens use to communicate their problems with us. Child abuse, teen pregnancy, sexually transmitted disease, substance abuse and teen suicide are discussed briefly, in snapshot glimpses. These elements have a synergistic effect when they combine to influence teen development.

I hope this issue of the *Journal* helps you when you work as a physician, a parent and a member of the community to see our teens safely through a difficult time.

If we must live with graffiti let's hope our efforts make it reflect less frustration and more exuberance and pride. ◀

All of us place burdens on the backs of our children that many of them cannot bear. Let's help lighten them. Let children be children.

people. A heart and initials on a tree, a sketch on a wall, a rude inscription or a “Kilroy Was Here.” It is a part of being human.

In this issue we consider teen health issues and the exuberant frustration from which so many problems that affect teenagers arise. Adolescents are the only age group in which the mortality rate has *risen* in the past 25 years. Violence in its many guises is the leading cause. Accidents, suicides and homicides rise out of unacceptable risk-taking and feelings of immortality and invincibility. Cautionary behavior is perceived as being “chicken.” Refusal to conform is suspect and peers are pressured to “go along—everybody's doing it.”

tive peer pressure. As parents and physicians, we can help.

We deliver driver education at home and school. We make sure they know how a car works and how to drive by the rules of the road and what happens if you break them. Similarly, we must make sure that teens know the facts of modern life. They must have sex education that is complete, accurate and appropriate.

The stress of realizing that they

Edward J. Fesco, M.D.
Edward J. Fesco, M.D.
President

THE VIEWBOX

CONTRIBUTING EDITOR TERRENCE C. DEMOS, M.D., PROFESSOR OF RADIOLOGY, DEPARTMENT OF RADIOLOGY, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was contributed by Kenneth Baliga, M.D., department of radiology, Rockford Memorial Hospital, Rockford, Illinois.

This 13-year-old boy has a history of seizures and an abnormal computed tomography study of the brain. (Figure 1) During evaluation in a genetics clinic a baseline ultrasound study of the kidneys was performed. Both kidneys demonstrated multiple small cysts. (Figure 2) Kidney size was normal.

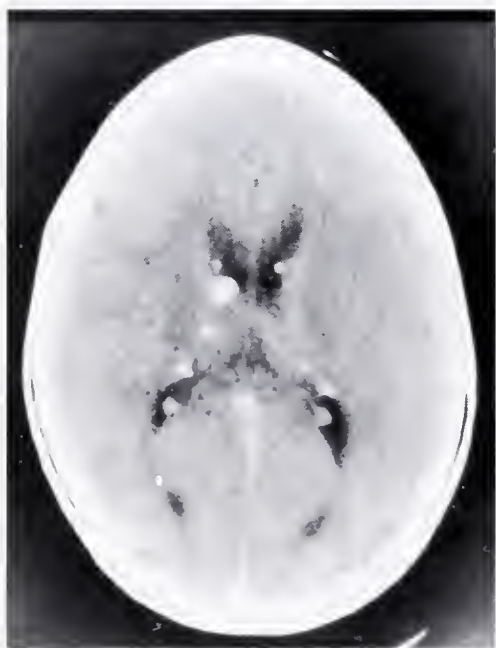


Figure 1
Brain CT shows multiple round periventricular calcifications.

Your diagnosis?

1. Infantile polycystic disease
2. Tuberous sclerosis
3. Adult polycystic disease
4. Medullary cystic disease

(continued on page 210)

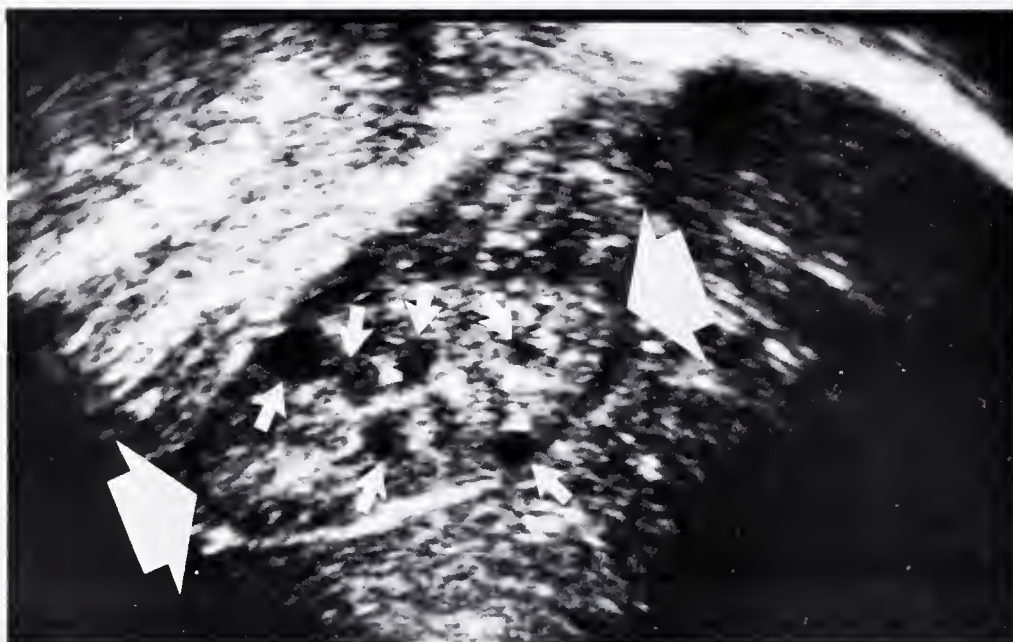


Figure 2
Renal sonogram—longitudinal section of the right kidney (large arrows). Small arrows indicate multiple cysts. There were cysts of the left kidney also.

Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

Contraindications: There are no known contraindications to the use of 'Tagamet'.

Precautions: While a weak antiandrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlorthalidone, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.),

demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported. Including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly un-

likely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only), and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

Liquid: 300 mg./5 ml. in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).

Injection:

Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage® Vials: 300 mg./2 ml. in single-dose, ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl (brand of cimetidine hydrochloride) Injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

* ADD-Vantage® is a trademark of Abbott Laboratories.

BRS-TG:L73B

Date of Issuance Apr. 1987

SK&F LAB CO.

Cidra, P.R. 00639

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in peptic ulcer:

RELIEF
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REWARD



Tagamet®
brand of cimetidine
First to Heal

You'll both feel good about it.

RESULTS

FOR YEARS OF
COMPLIANCE

1990
1989
1988
1987



NOT COMPLAINTS **IN HYPERTENSION**

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*Rarely causes • impotence² • depression³ • sleep disturbances³
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- **Long-term control as initial therapy or in combination**

- **Excellent patient acceptance reduces dropouts**

An estimated 80% of responders stay on HYTRIN long term, as shown in a two-year study³

Side effects generally were mild and transient. Dizziness and asthenia were the most common. Others reported significantly more frequently than with placebo were nasal congestion, peripheral edema, somnolence, nausea, palpitations, and blurred vision. Incidence of syncope (1.0%) was not significantly different from placebo.

- **One price for all dosage strengths**

Even if dosage is increased, patient cost is not increased

NEW HYTRIN[®] 1 mg
2 mg
5 mg
tablets

(terazosin HCl) **ONCE-A-DAY**
ONE PRICE

The first once-a-day alpha₁ blocker



advancing cardiovascular care

Please see accompanying brief summary
7083834

HYTRIN®
(terazosin hydrochloride tablets)

Brief Summary

CLINICAL PHARMACOLOGY: Pharmacodynamics: Clinical studies of terazosin used in once a day (majority) and b.i.d regimens with total doses usually in the range of 5-20mg/day, in patients with mild or moderate hypertension. Because terazosin, like all alpha antagonists, can cause large falls in blood pressure after the first dose or first few doses, the initial dose was 1mg in virtually all studies, with subsequent titration to a specified fixed dose or titration to a specified blood pressure end point.

Blood pressure responses were measured at the end of the dosing interval (usually 24 hrs.) and effects were shown to persist throughout the interval, with usual supine responses 5-10mmHg systolic and 3.5-8mmHg diastolic greater than placebo. The responses in the standing position tended to be somewhat larger, although this was not true in all studies. The magnitude of blood pressure responses was similar to prazosin and less than hydrochlorothiazide (in a single study). In measurements 24 hrs. after dosing, heart rate was unchanged.

Limited measurements of peak response (2-3 hrs. after dosing) during chronic terazosin administration indicate that it is more than twice the trough (24 hr.) response, suggesting some attenuation of response at 24 hrs., presumably due to a fall in blood terazosin concentrations at the end of the dose interval. This explanation is not established with certainty and is not consistent with the similarity of blood pressure response to once-a-day and b.i.d dosing. With the absence of an observed dose-response relationship over a range of 5-20mg, i.e., if blood concentrations fall to the point of providing less than full effect at 24 hrs., a shorter dosing interval or larger dose should lead to increased response. Measure blood pressure (BP) at the end of the dose interval, if response is not satisfactory, patients may be tried on a larger dose or b.i.d. regimen. The latter should be considered if side effects, such as dizziness, palpitations, or orthostatic complaints, are seen within a few hours after dosing.

The greater BP effect associated with peak plasma concentrations (first few hours after dosing) appears somewhat more position dependent (greater in the erect position) than the effect of terazosin at 24 hrs. In the erect position there is a 6-10 bpm increase in heart rate in the first few hours after dosing. During the first 3 hrs. after dosing 12.5% of patients had a systolic pressure fall of 30mmHg or more from supine to standing, or standing systolic pressure below 90mmHg with a fall of at least 20mmHg, compared to 4% of a placebo group.

INDICATIONS AND USAGE: Indicated for the treatment of hypertension.

CONTRAINDICATIONS: None known.

WARNINGS: Syncope and "First-dose" Effect: Terazosin, like other alpha-adrenergic blocking agents, can cause marked hypotension, especially postural hypotension, and syncope in association with the first dose or first few doses. A similar effect may occur if therapy is interrupted for more than a few doses. Syncope has been reported with other alpha-adrenergic blocking agents in association with rapid dosage increases or introduction of another antihypertensive drug. Syncope may be due to an excessive postural hypotensive effect, although occasionally the syncope episode has been preceded by severe supraventricular tachycardia with heart rates of 120-160 bpm.

To decrease the likelihood of syncope or excessive hypotension, always initiate treatment with a 1mg dose at bedtime. The 2mg and 5mg tablets are not indicated as initial therapy. Increase dosage slowly, and add additional antihypertensive agents with caution. Caution patients to avoid situations where injury could result if syncope occurs during initiation of therapy.

In early studies, where increasing single doses up to 7.5mg were given at 3 day intervals, tolerance to the first dose phenomenon did not necessarily develop and the "first dose" effect was observed at all doses. Syncope episodes occurred in 3 of 14 subjects given doses of 2.5, 5, and 7.5mg, which are higher than the recommended initial dose. Severe orthostatic hypotension (BP 50/0mmHg) was seen in two others and dizziness, tachycardia, and light headedness occurred in most subjects. These adverse effects all occurred within 90 min. of dosing.

In multiple dose clinical trials involving nearly 2000 patients, syncope was reported in about 1% of patients, in no case severe or prolonged, and was not necessarily associated with early doses.

If syncope occurs, place patient in recumbent position and treat supportively. There is evidence that the orthostatic effect of terazosin is greater, even in chronic use, shortly after dosing.

PRECAUTIONS: General: **Orthostatic Hypotension:** While syncope is the most severe orthostatic effect of terazosin, other symptoms of lowered BP, such as dizziness, lightheadedness and palpitations, are more common, occurring in 28% of patients in clinical trials. Patients with occupations in which such events represent potential problems should be treated with particular caution.

Information for Patients: Make aware of possibility of syncope and orthostatic symptoms, especially at initiation of therapy, and to avoid driving or hazardous tasks for 12 hrs. after the first dose, after a dosage increase, and after interruption of therapy when treatment is resumed. Caution to avoid situations where injury could result should syncope occur during initial therapy. Advise to sit or lie down when symptoms of lowered BP occur and to rise carefully from a sitting or lying position. Bothersome dizziness, lightheadedness, or palpitations should be reported to physician.

Tell patients that drowsiness or somnolence can occur, requiring caution in people who must drive or operate heavy machinery.

Laboratory Tests: Small but statistically significant decreases in hematocrit, hemoglobin, WBC, total protein and albumin were observed in clinical trials. The magnitude of decreases did not worsen with time. These findings suggest the possibility of hemodilution.

Drug Interactions: In controlled trials, terazosin was added to diuretics, and several beta-adrenergic blockers, no unexpected interactions were observed. Terazosin has also been used concomitantly without interaction in at least 50 patients on the following: 1) analgesic/anti-inflammatory (acetaminophen, aspirin, codeine, ibuprofen, indomethacin); 2) antibiotics (erythromycin, trimethoprim and sulfamethoxazole); 3) anticholinergic/sympathomimetics (phenylephrine HCl, phenylpropanolamine HCl, pseudoephedrine HCl); 4) antitussive (allopurinol); 5) antihistamines (chlorpheniramine HCl, clemastine fumarate, lorazepam, lorazepam, methchlorazide, promethazine); 6) corticosteroids; 7) gastrointestinal agents (antacids); 8) hypoglycemics; 9) sedatives and tranquilizers (diazepam).

Carcinogenesis, Mutagenesis, Impairment of Fertility: HYTRIN was devoid of mutagenic potential when evaluated in vivo and in vitro.

HYTRIN, administered in feed to rats at doses of 8, 40, and 250mg/kg/day for 2 yrs., was associated with a statistically significant increase in benign adrenal medullary tumors of male rats exposed to the 250mg/kg dose. This dose is 895 X max. recommended human dose (20mg/55kg). Female rats were unaffected. HYTRIN was not oncogenic in mice when administered in feed for 2 yrs. at a maximum tolerated dose of 32mg/kg/day.

The absence of mutagenicity in a battery of tests, of tumorigenicity of any cell type in the mouse carcinogenicity assay, of increased total tumor incidence in either species, and of proliferative adrenal lesions in female rats, suggests a male rat species specific event. Numerous other diverse pharmaceutical and chemical compounds have been associated with these tumors in male rats without supporting evidence for carcinogenicity in man.

Effects on fertility were assessed in a standard fertility/reproductive performance study in which male and female rats were administered oral doses of 8, 30 and 120mg/kg/day. Four of 20 male rats given 30mg/kg and 5 of 19 male rats given 120mg/kg failed to sire a litter. Testicular weights and morphology were unaffected. Vaginal smears at 30 and 120mg/kg/day appeared to contain less sperm than smears from control matings and good correlation was reported between sperm count and subsequent pregnancy.

Oral use for 1 or 2 yrs. elicited a statistically significant increase in testicular atrophy in rats exposed to 40 and 250mg/kg/day, but not in rats exposed to 8mg/kg/day (> 20 X max. recommended human dose). Testicular atrophy was observed in dogs dosed with 300mg/kg/day (> 800 X max. recommended human dose) for 3 months but not after 1 yr. when dosed with 20mg/kg/day. This lesion has also been seen with Minoxipress®.

Pregnancy: Teratogenic effects: Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women and the safety of terazosin in pregnancy has not been established. HYTRIN is not recommended during pregnancy unless potential benefit justifies potential risk to mother and fetus.

Nonteratogenic effects: In a peri- and post-natal development study in rats, significantly more pups died in the group dosed with 120mg/kg/day (> 300 X max. recommended human dose) than in the control group during the 3 week post-partum period.

Nursing Mothers: It is not known whether terazosin is excreted in breast milk; therefore, exercise caution when administering terazosin to a nursing woman.

Pediatric Use: Safety and effectiveness have not been determined.

ADVERSE REACTIONS: The prevalence of adverse reactions has been ascertained from 14 placebo controlled studies conducted primarily in the U.S. The studies involved once-a-day administration of terazosin as monotherapy or in combination with other antihypertensive agents, at doses ranging from 1 to 40mg. All adverse events reported during these studies were recorded as adverse reactions. Adverse events where the prevalence rate in the terazosin group was at least 5%, where the prevalence rate for the terazosin group was at least 2% and was greater than the prevalence rate for the placebo group, or where the reaction is of particular interest are summarized below. Only asthma, blurred vision, dizziness, nasal congestion, nausea, peripheral edema, palpitations and somnolence were significantly ($p < 0.05$) more common in patients receiving terazosin than in patients receiving placebo. Other events which were specific events. Numerous other diverse pharmaceutical and chemical compounds have been associated with these events in male rats without supporting evidence for carcinogenicity in man.

Headache (16.2%-15.8%), impotence (1.2%-1.4%), libido decreased (0.6%-0.2%), nasal congestion (5.9%-3.4%), nausea (4.4%-1.4%), nervousness (2.3%-1.8%), pain extremities (3.5%-3%), palpitations (4.3%-1.2%), paresthesia (2.9%-1.4%), peripheral edema (5.5%-2.4%), postural hypotension (1.3%-0.4%), sinusitis (2.6%-1.4%), somnolence (5.4%-2.6%), tachycardia (1.9%-1.2%), weight gain (0.5%-0.2%).

Adverse reactions were usually mild or moderate in intensity but sometimes were serious enough to interrupt treatment. Adverse reactions that were most bothersome as judged by being reported as reasons for discontinuation of therapy by at least 0.5% of the terazosin group and being reported more often than in the placebo group (*TERAZOSIN - PLACEBO) are: asthma (1.6%-0%), blurred vision (0.6%-0%), dizziness (2.1%-0.4%), dyspnea (0.9%-0.6%), headache (1.3%-1%), nasal congestion (0.6%-0%), nausea (0.8%-0%), palpitations (1.4%-0.2%), paresthesia (0.8%-0.2%), peripheral edema (0.6%-0%), postural hypotension (0.5%-0%), somnolence (0.6%-0.2%), syncope (0.5%-0.2%), tachycardia (0.6%-0%).

Additional adverse reactions have been reported, but these are not distinguishable from symptoms that might have occurred in the absence of exposure to terazosin. The following additional adverse reactions were reported by at least 1% of 1987 patients who received terazosin in clinical studies or during marketing experience: abdominal pain, abnormal vision, anxiety, arrhythmia, arthralgia, arthritis, bronchitis, chest pain, cold symptoms, conjunctivitis, constipation, diarrhea, dry mouth, dyspepsia, epistaxis, facial edema, fever, flatulence, flu symptoms, gout, increased cough, insomnia, joint disorder, myalgia, neck pain, pharyngitis, pruritus, rash, rhinitis, shoulder pain, sweating, urticaria, urinary frequency, urinary tract infection, vasodilation, vomiting.

DOSAGE AND ADMINISTRATION: Dose and dose interval (12 or 24 hrs.) should be adjusted according to BP response.

Initial Dose: 1mg at bedtime. Observe the initial dosing regimen strictly to minimize potential for severe hypotensive effects.

Subsequent Doses: Slowly increase dose to achieve desired BP response. Usual dose range is 1mg to 5mg once a day. Some patients may benefit from doses up to 20mg/day. Doses over 20mg do not appear to provide further BP effect. Doses not been studied. Monitor BP at the end of dosing interval. When BP at the end of dosing interval is maintained. It may be helpful to measure BP 2-3 hrs. after dosing to see if maximum and minimum responses are similar, and to evaluate symptoms which can result from excessive hypotensive response. If response is substantially diminished at 24 hrs, consider an increased dose or b.i.d. regimen. If administration is discontinued for several days or longer, reinstitute therapy using initial dosing regimen. In clinical trials, except for the initial dose, the dose was given in the morning.

Use With Other Drugs: Caution should be observed when terazosin is administered concomitantly with other antihypertensive agents (e.g., calcium antagonists) to avoid the possibility of significant hypotension. When adding a diuretic or other antihypertensive agent, dosage reduction and retitration may be necessary.

August, 1987 Abbott Health Care Products, Inc. North Chicago, IL 60064

7083834

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7083834

DOCTOR'S NEWS

ENGLISH LANGUAGE ADULT EDUCATION COURSES AVAILABLE

In April 1987, the ISMS Board of Trustees directed that the Council on Education and Manpower compile a listing of English language adult education courses available throughout Illinois and make these known to member physicians.

To comply with that request, the Council has obtained a directory listing over 500 ESL (English as a Second Language) courses which are available in Illinois. For information on specific courses in your area, please call or write the ISMS Division of Educational and Medical Services at Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602; 312/580-2466.

ABFP LAUNCHES NEW ACADEMIC JOURNAL

The American Board of Family Practice (ABFP) and the publishing division of the Massachusetts Medical Society, publishers of the *New England Journal of Medicine*, announce the publication of a new quarterly journal entitled *The Journal of the American Board of Family Practice*. Volume 1, Number 1 appeared in January, 1988.

The primary purpose of this journal, which is purely academic and will carry no advertising this first year, is to publish original papers pertaining to clinical investigations, case reports, review articles pertinent to family practice, editorial comments and book reviews. Relevant non-clinical material will also be considered. Submissions for consideration may be sent to the ABFP, 2228 Young Drive, Lexington, Kentucky. Subscriptions are available through the Massachusetts Medical Society, the *JABFP*, Subscription Department, 1440 Main Street, Waltham, MA 02154.

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 782-1654.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or

sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

April Allergy

Hypersensitivity to Penicillins and Cephalosporins
For: Interested physicians. Lecture, April 18, Holiday Inn, Chicago City Centre. **Sponsor:** Illinois Society of Allergy and Clinical Immunology, 800 E. Northwest Hwy., Suite 1080, Palatine, IL 60067. **Fee:** \$20 (dinner). **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** Diane Kubis. **Phone:** (312) 359-3090.

Cardiology

Eighth Annual Great Lakes Conference on High Blood Pressure
For: Interested physicians. Conference, April 18-20, Ann Arbor, MI. **Sponsors:** American Heart Association of Michigan, P.O. Box 160, Lathrup Village, MI 48076, and the Michigan Department of Public Health. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: To be determined. **Contact:** Tom Matz. **Phone:** (313) 557-9500.

Interventional Cardiology in the Acute MI Patient

For: Cardiologists and internists. Lecture, April 27, Marriott Oakbrook, Oak Brook, IL. **Sponsor:** Hinsdale Hospital, 120 N. Oak, Hinsdale, IL 60521 and Genetech. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour; AAFP Prescribed: 1 hour. **Contact:** Lorraine Friestad. **Phone:** (312) 887-2645.

Family Medicine/Gynecology

Geriatric Gynecology for the Primary Care Provider
For: Family practitioners and internists. Course, April 16, Merrillville, IN. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** \$25. **Reg. Limit:** 200. **Credit:** Category 1: 6 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Hematology/Oncology

Lymphoma 1988: New Diagnostic and Treatment Strategies
For: Interested physicians. Symposium, April 15, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** \$20. **Reg. Limit:** 200. **Credit:** Category 1: 6 hours; AAFP Prescribed: 6 hours; ADA: 6 hours. **Contact:** Loretta Giacometto. **Phone:** (800) 325-9862.

Impaired Physician

Impaired Physician Program
For: Interested physicians. Lecture, April 14, Starved Rock Lodge, Utica, IL. **Sponsors:** La Salle County Medical Society and the Illinois State Medical Society. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** Bernard Doyle, M.D., **Phone:** (815) 223-0567.

Impaired Physician Program

For: Interested physicians. Lecture, April 29, Moline, IL. **Sponsors:** Lutheran Hospital, 501 10th Avenue, Moline, IL 61265 and the Illinois State Medical Society. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** Medical Education. **Phone:** (309) 757-2611.

Internal Medicine/Family Medicine

Clinical Endocrinology '88
For: Internists and family practitioners. Lecture, April 9, Hyatt Regency Oakbrook, Oak Brook, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 6 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Neuroradiology

1988 Neuroradiology Review Course
For: General radiologists, neuroradiologists, neurosurgeons, neurologists, and residents. Course, April 30-May 1, Oakbrook Marriott Hotel, Oak Brook, IL. **Sponsors:** Loyola University Stritch School of Medicine, Dept. of CME and Department of Radiology, 2160 S. First Avenue, Maywood, IL 60153. **Fee:** \$170 for physicians, \$100 for residents. **Reg. Limit:** None. **Credit:** Category 1: 16 hours. **Contact:** Linda K. Gunzburger, Ph.D. **Phone:** (312) 531-3237.

Obstetrics/Gynecology

15th Annual Symposium on Obstetrics and Gynecology
For: Interested physicians. Symposium, April 28-29, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** \$200. **Reg. Limit:** 150. **Credit:** Category 1: 12 hours; AAFP Prescribed: 12 hours; ADA: 12 hours; ACOG cognates: 12 hours. **Contact:** Loretta Giacometto. **Phone:** (800) 325-9862.

Ophthalmology

Advanced Contact Lens Course
For: Ophthalmologists. Seminar, April 20-21, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** To be determined. **Reg. Limit:** 150. **Credit:** Category 1: 9 hours. **Contact:** Loretta Giacometto. **Phone:** (800) 325-9862.

Otolaryngology

Frontiers of Medicine: Recent Progress in Head and Neck Oncology
For: Otolaryngologists. Course, April 13, Chicago. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** To be determined.

Reg. Limit: 150. **Credit:** Category 1: 6 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Otology

Dizziness and Balance Disorders: Clinical Management in Primary Care
For: Interested physicians and allied health personnel. Symposium, April 16, Oak Brook Hills Hotel, Oak Brook, IL. **Sponsors:** Hinsdale Hospital, 120 North Oak Street, Hinsdale, IL 60521 and Illinois Academy of Family Practice. **Fee:** \$40 for physicians and \$25 for residents and allied health personnel. **Reg. Limit:** None. **Credit:** Category 1: 7 hours; AAFP Prescribed: 7 hours. **Contact:** Lorraine Friestad. **Phone:** (312) 887-2645.

Pathology

Future Trends in Evaluating Quality of Care
For: Pathologists. Lecture, April 11, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644, and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours for Chicago Pathology Society members only. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

Rehabilitation Medicine

Electromyography and Clinical Neurophysiology: A High Intensity Review
For: Electromyographers and senior residents. Course, April 4-7, Chicago, IL. **Sponsor:** Rehabilitation Institute of Chicago, 345 E. Superior Street, Ste. 1641, Chicago, IL 60611. **Fee:** \$425 for physicians; \$375 for residents. **Reg. Limit:** None. **Reg. Deadline:** March 20. **Credit:** Category 1: 21 hours. **Contact:** Ian MacLean, M.D. **Phone:** (312) 908-6098.

Urology

Frontiers in Endoscopy
For: Urologists. Workshop, April 15-16, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** To be determined. **Reg. Limit:** 80. **Credit:** Category 1: 11 hours. **Contact:** Loretta Giacometto. **Phone:** (800) 325-9862.

May

Allergy

Resident Fellow Program
For: Interested physicians. Lecture, May 16, Holiday Inn,

Chicago City Centre. **Sponsor:** Illinois Society of Allergy and Clinical Immunology, 800 E. Northwest Hwy., Suite 1080, Palatine, IL 60067. **Fee:** \$20 (dinner). **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** Diane Kubis. **Phone:** (312) 359-3090.

Echocardiography

Echocardiography

For: Interested physicians. Lecture, May 24, DeKalb, IL. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, Ext. 3484.

Emergency Medicine

1988 Illinois Combined Scientific Assembly

For: Emergency room physicians and other health professionals. Annual meeting, May 26-28, The Hamilton Hotel, Itasca, IL. **Sponsor:** Illinois Chapter of the American College of Emergency Physicians, 1645 Des Plaines Avenue, Des Plaines, IL 60018. **Fee:** \$105-225. **Reg. Limit:** None. **Credit:** Category 1: 16 hours. **Contact:** Jeannine Helms. **Phone:** (312) 298-1970.

Family Medicine

Treatment Decisions in AIDS

For: Family practitioners and internists. Symposium, May 19-21, Chicago, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** \$150. **Reg. Limit:** 500. **Credit:** Category 1: 18 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Infectious Disease

Viral Hepatitis—Type B

For: Interested physicians. Lecture, May 3, DeKalb, IL. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour; AAFP Prescribed: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, Ext. 3484.

Internal Medicine

Diabetic Neuropathy

For: Interested physicians. Lecture, May 31, DeKalb, IL. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, Ext. 3484.

Obstetricians/Family Practice

Teratology Conference: The Patient at Risk for Birth Defects—Physician Responsibility and Liability

For: Interested physicians. Conference, May 7, Illinois Masonic Medical Center, Chicago, IL. **Sponsor:** Illinois Masonic Medical Center, Reproductive and Medical Genetics Section, Department of OB/Gyn, 836 W. Wellington, Chicago, IL 60657. **Fee:** \$100. **Reg. Limit:** 150. **Credit:** Category 1: 8 hours. **Contact:** Janet Dalzell. **Phone:** (312) 883-7045.

Pathology

Pathology of the Neuroendocrine System

For: Pathologists. Slide seminar and annual dinner, May 9, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644 and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours for Chicago Pathology Society members only. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

Psychiatry

The Psychiatric Interview

For: Psychiatrists. Course, May 13-15, Chicago. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** \$375. **Reg. Limit:** 150. **Credit:** Category 1: 18 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Substance Abuse

Physician's Role in Recognizing Substance Abuse

For: Interested physicians. Lecture, May 5, Fishers Restau-

rant, Belleville, IL. **Sponsors:** St. Clair County Medical Society and Illinois State Medical Society. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1.5 hours. **Contact:** Adrienne Noubertian. **Phone:** (618) 397-7633.

Physician's Role in Recognizing Substance Abuse/Pediatric Substance Abuse/Diagnosis and Treatment of Cocaine Abuse

For: Interested physicians. Lecture, May 25, St. Therese Medical Center, 2615 W. Washington, Waukegan, Illinois 60085. **Sponsors:** St. Therese Medical Center and Illinois State Medical Society. **Reg. Limit:** None. **Credit:** Category 1: 3 hours. **Contact:** Marion Henderson. **Phone:** (312)

Surgery

Low Back Pain

For: Interested physicians. Lecture, May, 17, DeKalb, IL. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour; AAFP Prescribed: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, Ext. 3484.

June

Obstetrics/Gynecology

Obstetrics and Gynecology Review Course

For: OB/GYN's. Course, June 13-18, Chicago. **Sponsor:** University of Chicago, Center for Continuing Medical Education, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** \$550. **Reg. Limit:** 300. **Credit:** Category 1: 39 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Ophthalmology

Corneal Surgery for the Anterior Segment Surgeon: Hands-On Workshop

For: Ophthalmologists. Workshop, June 24-25, Chicago. **Sponsor:** The Cornea Service, Dept. of Ophthalmology, Rush-Presbyterian-St. Luke's Medical Center, 1753 W. Congress Parkway, Chicago, IL 60612. **Fee:** \$300. **Reg. Limit:** 100. **Credit:** Category 1: 16 hours. **Contact:** Victoria O'Sullivan, University Office of CME, 600 S. Paulina, Chicago, IL 60612. **Phone:** (312) 942-7119.

Contact Lens Fitting Course

For: Ophthalmologists. Course, June 3, University of Illinois Hospital, Eye & Ear Infirmary, Chicago. **Sponsor:** University of Illinois College of Medicine, Dept. of Ophthalmology, 912 S. Wood, Chicago, IL 60612. **Fee:** \$150. **Reg. Limit:** 200. **Credit:** Category 1: pending. **Contact:** Conference Registrar. **Phone:** (312) 996-5225.

Otolaryngology

Endoscopic Sinus Surgery Workshop

For: Otolaryngologists. Workshop, June 17-18, Chicago. **Sponsor:** University of Chicago School of Medicine, Office of Continuing Medical Education, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** 60. **Credit:** Category 1: To be determined. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Pathology

Seminar on New Technology

For: Pathologists. Lecture, June 13, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644 and Michael Reese Hospital and Medical Center. **Fee:** None. **Credit:** Category 1: 2 hours for Chicago Pathology Society members only. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

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Indications: Management of anxiety disorders; short-term relief of anxiety symptoms, acute alcohol withdrawal symptoms, preoperative apprehension and anxiety. Usually not required for anxiety or tension associated with stress of everyday life. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported after abrupt cessation of extended use of excessive doses are similar to those seen with barbiturates. Milder symptoms reported infrequently when continuous therapy is abruptly ended. Avoid abrupt discontinuation; gradually taper dosage.

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. **Oral—Adults:** Mild and moderate anxiety disorders and symptoms, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. **Geriatric patients:** 5 mg b.i.d. to q.i.d. (See Precautions.)

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Double Jeopardy

By JUDÉE GALLAGHER, J.D./CHICAGO

Your contract with an HMO, PPO or IPA includes an obligation to honor the organization's utilization review program. If you clear all the hurdles (which may be numerous), obtain prior authorization for referrals, inpatient admissions, certain outpatient care and a myriad of specific procedures, and follow the PPO protocols, you may feel secure that you will be paid for your services. After all, if you recommend certain tests and the PPO authorizes them, the PPO has given its stamp of approval: the tests are "medically necessary."

Generally speaking, this determination means that according to the PPO's severity of illness criteria, your patient's symptoms indicate that the tests are warranted. Practically speaking, it means that your patient will not have to pay for the tests and that you will be paid by the PPO. Or will you? Absolute statements about payment issues in many alternative delivery system contracts are illusory. It is certain, however, that if you administered tests which the PPO concluded were "medically unnecessary" the PPO would not pay you. Additionally, the PPO may prohibit you from billing the patient.

After examining test results and obtaining prior authorization from the PPO, suppose you admitted your patient to the hospital for treatment. Your patient was ready to leave the hospital by the end of the PPO's "length of stay" assignment, so you did not have to pursue an extended stay authorization. Because of your patient's stable condition, you were able to bypass prior authorization for home health

or skilled nursing home care. All in all, you have rendered care within the standards of your profession and have tried your best to contain costs.

Will you be paid by the PPO for your services? Maybe. The PPO did determine that the care was "medically necessary" during prior authorization. But payment is still not certain. Your PPO's cost containment program includes retrospective or "after the fact" review. Some contracts specifically provide that prior authorization does not guarantee payment if a retroactive denial of "medically necessary" is made during retrospective review. Other contracts put it this way: "PPO shall conduct retrospective review of all claims to verify that the care rendered was both appropriate and rendered at the most appropriate level of care." Many contracts simply name retrospective review as part of their cost containment program, leaving the door open for a second look at whether the care rendered was "medically necessary," and a second opportunity to deny payment for services.

If the contract specifically states, as some do, that retrospective review is confined to quality assurance and will not jeopardize payment for pre-authorized services, you have good reason to expect payment for those services. In considering any contract, it is important to view it as a whole. The best payment schedule may not be worth the instability created by a system which allows retroactive payment denials. Remember: all terms are negotiable, not only price.

Because you're an informed phy-

sician who recognizes the complex issues involved in contracts for the delivery of medical care, your first step is to send the contract offered you or your IPA to the ISMS Office of Contractual Services. As a *members only service*, the office will provide you objective comments on any HMO, PPO or IPA contract for the nominal fee of \$100. Contract reviews highlight "standard of care," compensation and insurance issues, and pinpoint ambiguous language and inconsistent or contradictory provisions.

The review is a basic tool to help understand the contract. It's a good first step, but never a substitute for careful reading of the contract itself. It's not legal advice and the office cannot recommend that any contract is good or bad and should or shouldn't be signed. Each physician (or physician's corporation or partnership) must make that decision. The informed physician's personal attorney and accountant must be consulted before decisions are made.

Your attorney has undoubtedly explained that when you are considering an Individual Participation Agreement with an HMO, PPO or IPA you may not band together with other physicians to negotiate the contract collectively, because that violates antitrust laws. You can, however, individually negotiate your own contract by yourself or with your personal attorney or financial advisor.

Judee Gallagher, J.D., is a Chicago private practice attorney retained by the ISMS Office of Contractual Services since 1985.

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sign,
negotiate

Before
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negotiate,
review



CONTRACT REVIEWS

The ISMS Office of Contractual Services reviews HMO, PPO and IPA contracts for members. The cost is \$100 per review.

These reviews do not constitute legal advice. They provide a working document which highlights key issues, such as malpractice coverage, reimbursement concerns and practice limitations.

For further information contact:

ISMS Office of Contractual Services
Twenty North Michigan Ave., Suite #700
Chicago, Illinois 60602
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...help for policyholders in avoiding the situations that can lead to suits; and

...premium rates that fairly reflect the risks inherent to the physician's own practice.

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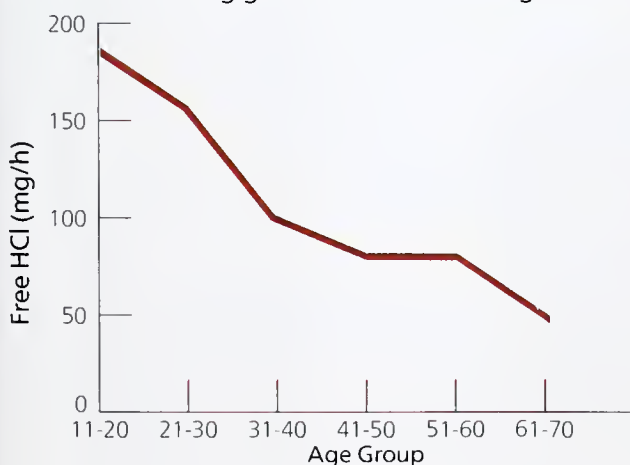
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BRIEF SUMMARY

CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate.

PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that the simultaneous administration of CARAFATE with tetracycline, phenytoin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. The clinical significance of these animal studies is yet to be defined.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No evidence of drug-related tumorigenicity was found in chronic oral toxicity studies of 24 months' duration conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies have not been conducted.

Pregnancy: Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED

CARAFATE (sucralfate) 1-gm pink tablets are supplied in bottles of 100 and in Unit Dose Identification Paks of 100. The tablets are embossed with MARION/1712. Issued 3/84

References:

1. Korman MG, Shaw RG, Hansky J, et al: *Gastroenterology* 80:1451-1453, 1981.
2. Korman MG, Hansky J, Merrett AC, et al: *Dig Dis Sci* 27:712-715, 1982.
3. Brandstaetter G, Kratochvil P: *Am J Med* 79(suppl 2C):36-38, 1985.
4. Marks IN, Wright JP, Gilinsky NH, et al: *J Clin Gastroenterol* 8:419-423, 1986.
5. Lam SK, Hui WM, Lau WY, et al: *Gastroenterology* 92:1193-1201, 1987.

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Illinois Society of Medical Assistants

Thirty-Second Annual Meeting

By CAROL ANN GASIOREK/NORRIDGE

The 32nd annual meeting of the Illinois Society of Medical Assistants, hosted by the Northwest Cook Chapter, will be held at the Westin O'Hare Hotel in Rosemont, Illinois on April 28-May 1, 1988. The theme for this year's meeting is "Superb Educational X-tras" and activities include the annual meeting of the Illinois Society plus extensive continuing educational sessions.

The official convention opening begins at 8:00p.m. on Thursday with a ribbon cutting ceremony. This will be followed by a welcome party and a campaign display where members can meet the candidates.

The 1988 House of Delegates will convene at 9:00a.m. on Friday, April 29. A number of issues will be brought before the House for discussion and voting. Members will have an opportunity to express their opinions and comments at reference committee meetings during the mid-morning break. Those eligible will vote after those meetings have concluded. The House will reconvene at 2:30 p.m. and adjourn at approximately 5:00 p.m.

The President's Dinner will begin at 7:30 p.m. with Cheryl Hutchison, CMA, presiding.

Educational programs will be offered Saturday and will feature the following topics:

- ☐ Depression
William A. Scheftner, M.D.
- ☐ Anxiety and Panic Disorders
Sushil Bagri, M.D.
- ☐ Sexual Dysfunctions
Speaker to be announced
- ☐ Transsexuals: Constructive and Reconstructive Surgery,

Endocrinology and Psychiatric Evaluation

Jack Berger, M.D.

- ☐ Marital Disharmony
Speaker to be announced

- ☐ Cross-Cultural Psychiatry, Unusual Aspects
Jack Berger, M.D.

- ☐ Dream Interpretations
K. Johansen, M.S.W., and Daniel Lindley, Jr., Ph.D.

The annual awards luncheon will take place on Saturday. The inaugural banquet will be held Saturday evening with cocktails at 6:30 p.m. and dinner at 7:30 p.m.

The new executive committee will meet Sunday at 8:00 a.m. The farewell brunch will be presented at 9:00 a.m. by the 1989 convention committee, Rock Island Chapter. The convention will close with a council meeting at 11:00 a.m.

Exhibits, arts and crafts, history books and chapter publications will be on display throughout the four-day convention.

We would like to express appreciation to the Northwest Cook Chapter for the time and effort devoted to hosting the 1988 Annual Meeting and to wish them every success.

For registration forms for the 32nd annual convention, please contact: Carol Ann Gasiorek, convention co-chairperson, 4935 North Sunrise Lane, Norridge, IL 60656 or Carole Wiczorek, CMA-C, convention co-chairperson, 15 Bar Harbour Road, #3A, Schaumburg, IL 60193.



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*Based on worldwide sales data on file, CIBA Pharmaceutical Company.
Capsule or tablet slow-release potassium chloride preparations should be reserved for patients who cannot tolerate, refuse to take, or have compliance problems with liquid or effervescent potassium preparations because of reports of intestinal and gastric ulceration and bleeding with slow-release KCl preparations.

Before prescribing, please consult Brief Prescribing Information on next page.

C I B A

The World's Most Popular K

For good reasons

- ☐ **It works**—a 12-year record of efficacy¹
- ☐ **It's safe**—unsurpassed by any other KCl tablet or capsule^{2*}
- ☐ **It's acceptable vs liquids**—greater palatability, fewer GI complaints, lower incidence of nausea²
- ☐ **It's comparable to 10 mEq**—in low-dosage supplementation^{3†}
- ☐ **It's economical**—less expensive than all other leading KCl slow-release supplements on a per tablet cost to the patient¹



Slow-K[®]
potassium chloride
slow-release tablets 8 mEq (600 mg)

For patients who can't or won't tolerate liquid KCl.

*The most common adverse reactions to potassium salts are gastrointestinal side effects.

†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

C I B A

References: 1. Data on file, CIBA Pharmaceutical Company. 2. Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. 3. Skoutakis VA, Carter CA, Acchiardo SR: Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

Slow-K[®]
potassium chloride USP
Slow-Release Tablets
8 mEq (600 mg)

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

INDICATIONS AND USAGE

BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see DVERDDSDAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS

Hyperkalemia (See DVERDDSDAGE).

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients

Physicians should consider reminding the patient of the following:

To take each dose without crushing, chewing, or sucking the tablets.

To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and DVERDDSDAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking dose with meals or reducing the dose.

Skin rash has been reported rarely.

DVERDDSDAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, excretory mechanisms are impaired or if potassium is administered rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave depression of S-T segment, and prolongation of the Q-T interval). Manifestations include muscle paralysis and cardiovascular collapse leading to cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, rapid lowering of the serum potassium concentration can produce digitalis toxicity.

DOSAGE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq/day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dose must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and not crushed, chewed, or sucked.

HOW SUPPLIED

Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, bicolored, sugar-coated (imprinted Slow-K).

Bottles of 100 NDC 0083-0165-

Bottles of 1000 NDC 0083-0165-

Consumer Pack—One Unit NDC 0083-0165-

12 Bottles—100 tablets each NDC 0083-0165-

Accu-Pak[®] Unit Dose (Blister pack) NDC 0083-0165-

Box of 100 (strips of 10) NDC 0083-0165-

Do not store above 86°F (30°C). Protect from moisture. Protect from light.

Dispense in tight, light-resistant container (USP).

Dist. by:
CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

C87-31 (Rev. 8/8)

C I B A

128-3568-



ILLINOIS

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scored tablets



2 mg



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The one you know best.

CMS and ISMS Merge Insurance Programs

There is a new organization on the horizon and you will soon be seeing its logo coming across your desk. The organization is not really new; the Physicians' Benefits Trust, as it is called, is the result of a merger of the Chicago Medical Society Insurance Trust with the benefit insurance programs of the Illinois State Medical Society.

For many years, the two societies sponsored the same types of benefit plans to some of the same physician members. Both societies offered major medical, disability, term life and other plans to Chicago and Cook County physicians. ISMS offered their programs to downstate members as well. Physicians were solicited by both organizations.

About a year ago, the leading members of the two organizations began to talk about combining the programs. They began to learn that by doing so, both organizations would benefit, but more importantly, the physician members would benefit. By combining the participants and premium dollars of the insurance programs, it would be easier to negotiate better programs with more benefits to the members than both organizations could do individually. In addition, the two organizations were competing with



each other for participants instead of working together for the benefit of the members. The merger would eliminate this and reduce costs and decrease duplication of efforts for both organizations.

Thus, the Physicians' Benefits Trust was born and will begin to offer benefit insurance plans to physician members throughout Illinois.

The first step of the merger was to have the same broker/administrator, Gerald J. Sullivan and Associates, Inc., named to handle the programs of the Illinois State Medical Society and the Chicago Medical Society Insurance Trust. The administrators went to work immediately, familiarizing themselves with the plans and negotiating with insurance companies to offer the best programs possible.

Meanwhile, a new Board of Trustees was named, with Chicago

Medical Society appointing six members to the Board and Illinois State Medical Society appointing three. The Chicago Medical Society Board of Trustees appointed Drs. Joan E. Cummings, Arvind K. Goyal, Alan M. Hollett, Arthur R. Peterson, Earl N. Solon, and M. LeRoy Sprang. The Illinois State Medical Society Board of Trustees appointed Drs. Raymond A. Dieter, Jr., Glen Ellyn, Alfred J. Kiessel, Decatur, and Michael Snyder, Springfield to the Board.

With the new Board appointed, organizational meetings were held to approve a new trust document, develop a new logo, approve a budget and discuss the alternatives for the best insurance plans available at the lowest cost to members. The administrators have developed a plan to market the improved programs to members of Chicago Medical Society and Illinois State Medical Society.

Physician members will begin to receive information on the improved plans in the spring of this year. The trustees of the Physicians' Benefits Trust and the leadership of the Chicago Medical Society and Illinois State Medical Society urge you to take a careful look at these new plans. ◀

Introducing...



Physicians' Benefits Trust

sponsored by Chicago Medical Society & Illinois State Medical Society

The Best of Two Respected Protection Programs

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- Excess Major Medical
- Medicare Supplement
- Hospital Indemnity
- Dental
- Long Term Disability
- Term Life
- Accidental Death & Dismemberment
- Personal Umbrella
- Office Overhead
- Group Practice Major Medical, Dental, Life & Disability

Administered by Gerald J. Sullivan & Assoc., Inc.

For information or to enroll, call
(312) 559-9130

Or complete and mail coupon to:

Physicians' Benefits Trust
222 South Riverside Plaza, Suite 2360
Chicago, IL 60606

Yes! Send information and enrollment forms
for the plans I have checked.

- ☐ Major Medical
- ☐ Excess Major Medical
- ☐ Medicare Supplement
- ☐ Hospital Indemnity
- ☐ Dental
- ☐ Long Term Disability
- ☐ Term Life
- ☐ Accidental Death & Dismemberment
- ☐ Personal Umbrella
- ☐ Office Overhead
- ☐ Group Practice Major Medical, Dental, Life & Disability

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PBT Physicians'
Benefits Trust
sponsored by Chicago Medical Society & Illinois State Medical Society

A better alternative for hypertensives who are going bananas...

Spare your patients the extra cost—
in calories, sodium and dollars.

Spare your patients the rigors of
dietary K⁺ supplementation.

DYAZIDE[®]

25mg Hydrochlorothiazide/50mg Triamterene/SKF

Effective antihypertensive*
therapy...without
the bananas

DAW
'DYAZIDE' AS WRITTEN.

* Not for initial therapy. See brief summary.

Before prescribing, see complete
prescribing information in
SK&F CO. literature or PDR.
The following is a brief summary.

* WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.
Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or

without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin (ACTH)). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The

following may occur, transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress (including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ:L45

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Penetration plus Duration*

Superior tissue penetration and duration of action

DURICEF[®]

(CEFADROXIL)

... the oral cephalosporin with
once- or twice-a-day dosing

*May not correlate with clinical results.

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For Brief Summary, please see following page.

DURICEF® (CEFADROXIL)

Penetration plus Duration
in Oral Cephalosporin Therapy

INDICATIONS: DURICEF (cefadroxil) is indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms: Urinary tract infections caused by *E. coli*, *P. mirabilis*, and *Klebsiella* species. Skin and skin structure infections caused by staphylococci and/or streptococci. Pharyngitis and tonsillitis caused by Group A beta-hemolytic streptococci. (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. DURICEF is generally effective in the eradication of streptococci from the nasopharynx; however, substantial data establishing the efficacy of DURICEF in the subsequent prevention of rheumatic fever are not available at present.)

Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

CONTRAINDICATIONS: DURICEF is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

WARNING: IN PENICILLIN-ALLERGIC PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF PENICILLINS AND CEPHALOSPORINS, AND THERE ARE INSTANCES OF PATIENTS WHO HAVE HAD REACTIONS TO BOTH DRUGS (INCLUDING FATAL ANAPHYLAXIS AFTER PARENTERAL USE).

Any patient who has demonstrated a history of some form of allergy, particularly to drugs, should receive antibiotics cautiously and then only when absolutely necessary. No exception should be made with regard to DURICEF (cefadroxil). **Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use.** Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Moderate to severe cases should be managed with fluid, electrolyte and protein supplementation as indicated. When the colitis is not relieved by drug discontinuance or when it is severe, oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should also be considered.

PRECAUTIONS: Patients should be followed carefully so that any side-effects or unusual manifestations of drug idiosyncrasy may be detected. If a hypersensitivity reaction occurs, the drug should be discontinued and the patient treated with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

DURICEF (cefadroxil) should be used with caution in the presence of markedly impaired renal function (creatinine clearance rate of less than 50 ml/min/1.73M²). (See Dosage and Administration section of Prescribing Information.) In patients with known or suspected renal impairment, careful clinical observation and appropriate laboratory studies should be made prior to and during therapy.

Prolonged use of DURICEF may result in the overgrowth of non-susceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug. DURICEF should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to 11 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cefadroxil. There are, however, no adequate and well controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Caution should be exercised when cefadroxil is administered to a nursing mother.

ADVERSE REACTIONS: *Gastrointestinal*—Symptoms of pseudomembranous colitis can appear during antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity—Allergies (in the form of rash, urticaria, and angioedema) have been observed. These reactions usually subsided upon discontinuation of the drug.

Other reactions have included genital pruritus, genital moniliasis, vaginitis, and moderate transient neutropenia.

Before prescribing or administering, see package insert

PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

ALTON:

Population in St. Louis metro area is over 2 million. Located 25 miles from downtown St. Louis. Four community hospitals available for staff privileges.¹ Opportunities for internal medicine, cardiology, neurology, gastroenterology, pediatrics, oncology, and anesthesiology. Fully equipped offices available. Scheduled hours, free rent, staff salary support, marketing assistance, partnership shares are available and attractive income support arrangements. Contact Jan C. Vest, Administrator, Doctors Clinic, Alton, Illinois (618) 474-8000 or 800-325-3571. (6)

CRYSTAL LAKE:

Population 20,000. Three board certified family practitioners, losing an associate July, 1988. Service area—35,000. Community offers fine opportunity for fulfilling medical practitioner, numerous cultural, recreational facilities, good family life. Contact: John Wall, 280 Virginia, Crystal Lake, 60014 (815) 459-2678 (6)

FREEPORT:

Four busy board certified FPs seeking board certified FP. Pleasant town of 30,000. 100 miles from Chicago. Contact: Family Medical Associates, 1815 W Church St., Freeport 61032; (815) 235-3165.(1)

LIBERTYVILLE:

Group of 4 primary care physicians: 1-general practitioner, 1-internal medicine, 2-F.P.—in Lake County.

We need additional F.P. with O.B. interest. Offices in Libertyville, Gurnee and Antioch. 30 miles north of Chicago. Guaranteed 1st year salary. All recreational facilities nearby. Contact: David D. Soo, M.D., Rt. 1, Box 351, Libertyville 60048; (312) 362-9050. (12)

MACOMB:

Chief of staff. Western Illinois University is accepting applications for medical chief of staff at its Health Center. This is a 12 month position in a multi-faceted outpatient clinic serving 11,000 students. Starting date July 1, 1988. Salary competitive and commensurate with experience. Excellent fringe benefits, malpractice paid. A letter of application along with a curriculum vitae and three references should be forwarded to: Mr. Earl Bracey, Chairman, Search Committee for Medical Chief of Staff, 315 Sherman Hall, W.I.U., Macomb, IL 61455. Ethnic minorities, women and handicapped persons are encouraged to apply. (6)

ROBINSON:

OB/GYN: BC/BE needed in family oriented community with a drawing area of 25,000. Progressive JCAH approved 107 bed hospital. Excellent medical staff. Highly competitive compensation package including income, office space, personnel, etc. Excellent opportunity for GYN Surgery. Hospital located in Southern Illinois near large referral centers, shopping centers. Contact: M. Jean Chambless, Administrator, Crawford Memorial Hospital, Robinson, Illinois 62454 (6)

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Soon more than a million insulin users will be taking Humulin.

And no wonder. Humulin is identical to the insulin produced by the human pancreas—except that it is made by rDNA technology.


Humulin is not derived from animal pancreases. So it contains none of the animal-source pancreatic impurities that may contribute to insulin allergies or immunogenicity.

The clinical significance of insulin antibodies in the complications of diabetes is uncertain at this time. However, high antibody titers have been shown to decrease the small amounts of endogenous insulin secretion some insulin users still have. The lower immunogenicity of Humulin has been shown to result in lower insulin antibody titers; thus, Humulin may help to prolong endogenous insulin production in some patients.

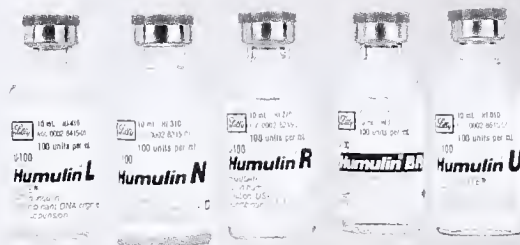
Any change of insulin should be made cautiously and only under medical supervision. Changes in refinement, purity, strength, brand (manufacturer), type (regular, NPH, Lente®, etc), species/source (beef, pork, beef-pork, or human), and/or method of manufacture (recombinant DNA versus animal-source insulin) may result in the need for a change in dosage.



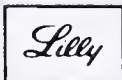
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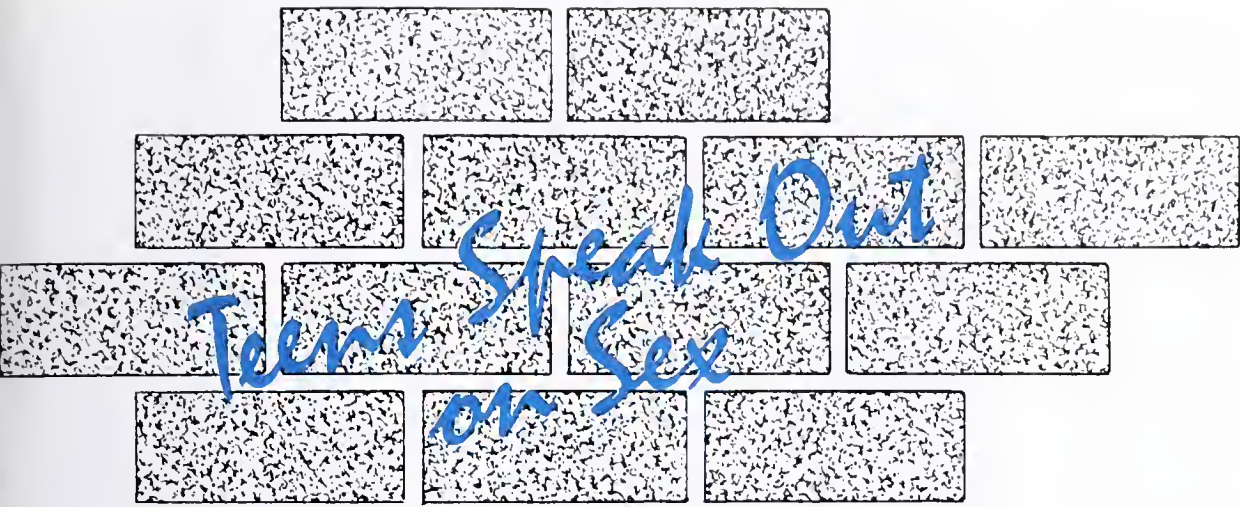
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Are teens getting the sexual education they need from parents, physicians and schools? How do teens view the threat of getting AIDS from casual sexual practices? What information—either myth or fact—is shaping their attitudes about sexuality, pregnancy and the risk of AIDS? Illinois State Medical Society President Edward J. Fesco, M.D., asked teens these questions on two separate occasions—in suburban Chicago and in downstate East St. Louis.

“You’re having a great senior year, you’re about to graduate from high school, you’ve had a good relationship with a boyfriend—and suddenly there’s a baby on the way. It happens all the time,” cautioned Edward J. Fesco, M.D., to an overflow crowd of students at Lincoln Senior High School, East St. Louis, Illinois.

Fesco’s February visit to the St. Clair County school was part of the annual ISMS President’s Tour of the state, which gives the Society’s spokesman an opportunity to meet with county medical societies, community groups, members of the media, and—this year—school children. This year the focus is on adolescent health issues, especially the need for sex education of teens to prevent the spread of AIDS. At the school, Dr. Fesco was joined by two local ISMS members: pediatrician Kenneth Haller and psychiatrist Phillip Dennis.

Statistics: Grim Indicators of Teen Vulnerability

Statistics on adolescent sexual behavior are indeed alarming.

According to the American Medical Association, about 12 million of our nation’s 29 million adolescents are sexually active. The mean age for first intercourse is less than 15 years. An estimated 50 percent of teens 15 to 19 years old fail to use any contraception during their first intercourse and two-thirds do not use birth control routinely thereafter. These are grim indicators of adolescents’ incredible vulnerability to pregnancy and sexually transmitted disease. And they explain why public health officials are worried that teens may become the next target for spread of the deadly AIDS virus.

The approximately 1.1 million teen pregnancies annually (including 22,000 Illinois teenage births in 1986) take their toll in health care, emotional and monetary costs. Both teen mothers and their babies suffer greatly increased mortality risks, when compared to women giving birth in their 20s. One-third of all abortions are obtained by teenagers. Teen mothers often lack the proper education and skills to compete in the job marketplace: two-

thirds do not finish high school. A New York City study showed that there are almost half again as many unemployed mothers in their teens as in their twenties. And adolescent mothers aged 15 to 17 years are 4.6 times more likely to be on welfare than those who give birth in their twenties. The total bill for adolescent child bearing, according to a 1985 Center for Population Options study: \$16.6 billion.

The Problem: Teen Invincibility

Perhaps the most deadly cost is one not yet widely recognized by the teen community—the threat of contracting AIDS. Said one suburban Chicago teen interviewed in January on the cable show ‘Teenage,’ “Teens don’t realize what AIDS is about until a friend is stricken or it happens to you.” The show featured a group of suburban Chicago teens discussing sex and AIDS with Fesco and ISMS Ad Hoc Committee on AIDS chairman Richard J. Sassetti, M.D.

A big part of the problem, according to Fesco and a variety of adolescent health experts, is “teenage invincibility and immortality. They take risks which adults would never take—doing wheelies, skating on the edge of the ice, driving too fast, drinking and getting into cars.” While it’s difficult to break through that “it can’t happen to me,” barrier, Fesco and Sassetti believe that early, complete and

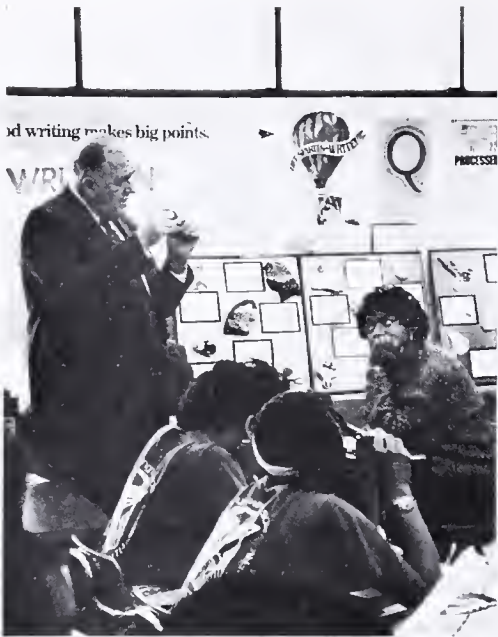
appropriate sex education is the best hope for preserving the health of teens as they confront a deadly disease.

The Solution: Sex Education

Many teens are fortunate enough to hear forthrightly from parents the facts of reproduction, coupled with the values so important to helping teens make responsible sexual choices. But many others learn sex education from the teenage grapevine. "There are lots of uninformed teens on sexual issues," related one suburban Chicago participant in 'Teenage.' East St. Louis adolescents echoed that view. "Who teaches kids about sex? Kids do," said one. "But the kids who really know about the risks and dangers of sexual activity get it from home." Said another teen, "Instead of interviewing us, we need more doctors like you to interview our parents."

While parents often tell adolescents to "just say no," many of the interviewed teens said they need to hear more factual, unbiased information on why saying no is so important. "Parents and physicians should explain to me 'why not'; what are the risks; what's bad about it; what's good about it."

Students said they also need to hear about the medical facts and consequences of sexual activity—including AIDS transmission—from sources other than parents. "The message is more effectively



Students at Lincoln Senior High School in East St. Louis, Illinois, learn from Edward J. Fesco, M.D., how the AIDS virus is transmitted. Dr. Fesco spoke to the students as part of his President's Tour.

Sassetti, a combination of both parents and physicians relaying the information is best. "The tragic part is that we physicians can teach the medical facts, but not the values. One of you teens asked if abstinence is realistic for adolescents. This is a value you learn at home—where value systems originate—that makes it easy for teens to prac-

tice abstinence."

Sharon Ahart, M.D., director of the pediatric ecology unit at Chicago's Mt. Sinai Hospital sees "a lot of teenagers molding their life just like their mothers or those around them. Many girls I deal with just

don't realize they can say no. They don't have self esteem, good role models." For these adolescents, school-based sex education serves as the core of their learning.

When kids do receive education in school, many view it as "a little too late." "Bring sex education into the school system at an early stage in the child's life," recommends one East St. Louis teen. "Fifth or sixth grade would be good, because by the time I was in ninth grade, the seventh graders were coming in six and seven months pregnant." Teens also want to learn more specifically about coping skills, "the tactics to say no." Lincoln Senior High School has just such a program. "Anyone can say no and not mean it," announced one student involved in the 'Just Say No' effort. "Do you mean what you say and say what you mean?" The program uses peer pressure to foster sexual abstinence in the student population.

Illinois Doctors Advocate Teen Sex Education and Health Services

The Illinois State Medical Society's House of Delegates has also recognized that today's adolescents

While parents often tell adolescents to "just say no," many of the interviewed teens said they need to hear more factual, unbiased information on why saying no is so important.

heard," asserted one East St. Louis teen, "when someone with an unbiased opinion—such as a doctor—provides the information. I'm more relaxed, which helps the message sink in."

According to AIDS chairman

Reason for Last Non-Use of Contraception

From Females Never Having Been and Not Trying to Become Pregnant, Age 15-19 (N = 337)

Reason	Percent Who Gave Reason
Wrong time of month	25
Unanticipated intercourse	22
Too young to become pregnant	9
Contraception wrong or dangerous	7
Infrequency of intercourse	6
Contraceptive information lacking	5
Miscellaneous	24

(Source: "The AMA White Paper on Adolescent Health," 1986. Reprinted with permission of the American Medical Association.)

Sexually Transmitted Disease

Adolescents who engage in sexual activity are prey to high levels of sexually transmitted diseases. Syphilis, gonorrhea, and chlamydia are the most common. AIDS is the most recent.

■ The highest incidence of sexually transmitted disease occurs in the 20-24 age group; the next highest is in the 15-19 age group.

■ The Children's Defense Fund estimates that one million teens contract chlamydial

infection each year.

■ The increasing prevalence of gonorrheal and chlamydial coinfection has led the Centers for Disease Control to recommend tetracycline in addition to ampicillin or penicillin in treatment of uncomplicated adult gonococcal infection.

■ Pelvic inflammatory disease is diagnosed in an estimated 250,000 adolescents each year. Of these, 15% will suffer from fertility problems. ◀

need school-based health care services, including sex education. ISMS policy adopted in 1971 and reviewed in 1986 advocates a "preventive medicine approach to the problem of unwanted pregnancies." It recommends spreading the word to adolescents about medical risks and consequences of sexual activity, through family life education in schools, and wider dissemination of family planning information, including birth control information and devices.

Beyond sex education lies the issue of school-based health clinics and just what services they provide. The Illinois State Medical Society "supports the concept of local Boards of Education establishing school-based programs or clinics, as appropriate, that may provide health and sex education, counseling and access to physical and mental health care services, as determined by the communities in which the clinics exist. Local physicians should become involved in planning and delivery of those services."

While sex education and school-based health clinics both spark controversy, opposition seems to be waning. A 1985 survey by the American College of Obstetricians and Gynecologists found 85% of respondents supported sex education as part of school curriculum. That figure dropped to 67% when people were asked if they support family planning clinics in schools. Yet, in certain areas of our state, family planning services are secondary or even nonexistent compared to the host of health services clinics provide. In these areas, school health clinic services may be the *only* medical care that adolescents receive.

Teens Need to Hear the Facts from Doctors

Since physicians can and should play such an important role in the sex education of adolescents, how might they best approach the subject with teenage patients?

Both East St. Louis and suburban Chicago students had recommendations for physicians. Several felt physicians "don't tell you enough, don't take the time to explain what's wrong—or tell you that they don't know yet what's wrong,"



Edward J. Fesco, M.D., (R) and Richard J. Sassetti, M.D., discuss AIDS with suburban Chicago teens on the cable television show "Teenage," filmed in January.

asserted one teen. Responded Fesco, "You have to ask, too. It works both ways. If you say, 'now listen, doc, this scares the devil out of me and I have to have more information,' you're likely to get more time and attention when you need it."

Another student lamented that some physicians talk more to parents about a health problem than they do to the adolescent patient. "If your parents don't relay the information, you're left wondering,

'what medical problem do I really have?'" Fesco told students to work on their parents to get the information. "In any event, at least tell the nurse or someone in the physician's office that you need more information, and you're not getting what you expect from medical care."

"Education in layman's terms—so we can understand it," is what many teens desire from their doctors. "There will always be 'but ifs,'" recognized one teen, when

doctors provide sex education information and counseling. One such 'but if' might involve discussing birth control, as opposed to simply advocating abstinence.

Physicians must also stress that preventive pregnancy measures do not always protect against sexually transmitted diseases like AIDS, according to Fesco. "Couples not wanting a pregnancy often rely on condoms, which have a 10-15 percent failure rate," he warned. For

Teens and AIDS: Exploring the Myths and the Facts

Only eleven AIDS cases have been found in adolescents between the ages of 13 and 19, since the Illinois Department of Public Health began keeping records in 1982. There have been 20 reported cases in children under age 13. But 340 young adults aged 20 to 29 have been stricken. These January, 1988 statistics may seem to contradict public health officials' warnings that AIDS poses a great threat to teen health. Since the virus can, however, remain latent for months to years, many young adults may have actually contracted AIDS through sexual encounters in their teens.

Teens interviewed for this story have certainly heard of the AIDS virus. But many myths and misconceptions cloud their thinking—just as is the case for adults. Here is a listing of the most commonly cited questions, concerns and myths about AIDS from teens at East St. Louis' Lincoln Senior High School and suburban Chicago's "Teenage" cable television discussion of the issue.

■ *If I shake hands with or kiss someone who has AIDS, can the virus be transmitted through sweat or saliva?*

"There's not much AIDS virus in saliva," answered

Richard Sassetti, M.D., chairman of the ISMS Ad hoc Committee on AIDS. "It can be cultured in the laboratory by working very hard, but it certainly can't be transmitted casually," he explained.

"There must be exchange of blood or bodily fluids such as semen or vaginal secretions."

ISMS President Edward J. Fesco, M.D., added, "A deep french kiss, when the partner's mouth has an open sore or blister, or bleeding gums, could pose a risk—because of the presence of blood."

■ *Doesn't the risk of getting AIDS really apply to those who repeatedly engage in casual sex with different partners?*

"The important thing to remember about AIDS is that *even one* contact involving exchange of bodily fluids or blood is enough to transmit the virus," warned Sassetti.

■ *Is using a condom safe sex?*

"The term 'safe sex' is not really used any more," noted pediatrician Kenneth Haller of East St. Louis, who accompanied Fesco to Lincoln Senior High School in February. "There are some prac-

tices called 'safer sex'—safer, that is, than going without a condom. But nothing is absolutely safe if there is any kind of sexual penetration," he cautioned.

■ *Who's to say that a potentially more dangerous AIDS virus couldn't come up?*

"AIDS is only one of a whole family of viruses," according to Sassetti, "for which there is no vaccine. That's why we're talking about celibacy as the only real alternative for you—for a long time to come."

■ *If you date a person for five or six years, and then get married, is it safe to have sex without fearing AIDS?*

"It's very horrible to consider that someone you marry may have the AIDS virus," said Fesco. "The vast majority of those carrying the AIDS virus test positive within a few months or a year."

Sassetti added that "the incubation period means a person can have the virus without testing positive right away. That is why it's so important for teens, as individuals, to take serious

Illinois Teen Pregnancies: The Top Counties

Approximately 12.5 percent of all 1986 live births were to teen mothers throughout Illinois. But that statewide average fails to reflect much higher teen birth rates in specific regions of our state. Listed below are the top Illinois counties for teen births in 1986. The figures, supplied by the Illinois Department of Public Health, indicate births to teens as a percentage of all live births in each county.

Pope County	26.0%
Pulaski County	20.2%
Alexander County	19.6%
St. Clair County	18.6%
Cook County (Chicago only)	18.5%
Hamilton County	18.0%
Marion County	17.9%
Edgar County	17.8%
Massac County	17.8%
Pike County	17.5%
Kankakee County	17.2%
Saline County	17.1%
Hardin County	16.3%
Macon County	16.3%
Vermilion County	16.2%
Warren County	16.1%

AIDS transmission the failure rate can be higher, since AIDS, unlike pregnancy, can occur *any* time bodily fluids are exchanged. "The odds of condom failure put you at high risk for AIDS," he explained.

Mt. Sinai Hospital's Ahart offers

anatomy and physiology; basic sexual functioning, including common sexual myths and alternatives to intercourse; the health consequences of sexual intercourse; the relationship between having sex, using birth control, getting preg-

The tragic part is that we physicians can teach the medical facts, but not the values.

advice to physicians discussing sexuality with adolescent patients. "I am very direct with them. I tell them that they are too young, emotionally not ready for sexual activity. You should not be having sex just because you want to please someone. You must please yourself. You should also use some protection," she warns teenage girls, "because I can show you statistics that when you get pregnant, the guy doesn't often hang around. You end up raising a child by yourself."

A solid foundation of medical facts on sexual activity is, in essence, what teens need to weave their way through the pitfalls of adolescence. According to the American Medical Association, such information should include "basic reproduction

nant and being a parent; the similarities and differences between male and female roles; the components of sexual decision making; and available resources to answer concerns, questions or problems."

That is a mammoth yet essential undertaking, in light of the new, deadly strain of sexually-transmitted disease. It is clear from these interviews that Illinois teens are relying on physicians for medical information to protect them. Said Dr. Fesco, as he took his leave of Lincoln Senior High School, "Doctors are growing in the understanding of what adolescents need, in terms of care and counseling about sex." That indeed is good news for Illinois adolescents.

responsibility now for their sexual future. Abstinence is the best safeguard."

■ *I heard that two people having anal sex can catch the virus—even though neither had it to begin with. Is this true?*
"No. There would have to be virus in either partner for AIDS to be contracted," responded Fesco.

■ *Do mosquitoes carry the AIDS virus? Are we at risk from a bite?*
"The virus has to live and be transmitted a certain way," answered Fesco. "No one has been able to prove that mosquitoes carry the virus. Malaria, which is carried by

mosquitoes, is a completely different germ, with a different composition than AIDS. The situations aren't comparable, because the germs are so different."

■ *Is donated blood safe? Can AIDS be contracted from blood transfusions?*
Blood banks test every unit of blood for AIDS virus before it is used," answered Sassetti. "So the risk of getting AIDS from a blood transfusion is very, very low—about 1 in 500,000—but not zero," he explained. "Put in perspective, it's geometrically lower than other risks you face every day."

■ *What should a teen who is worried he or she might have been exposed to the AIDS virus do?*
"See your family physician right away to talk about it and to possibly be tested," advised Fesco.

A final word from Fesco to teens was, "Don't believe everything you read or see about AIDS. If tomorrow a newspaper reports that AIDS virus may be found in milk, don't necessarily believe it." He encouraged teens to "think about AIDS, what we know and what we don't. Knowledge and common sense will help you find the truth. Don't be afraid to ask your family doctor for more information," he concluded.



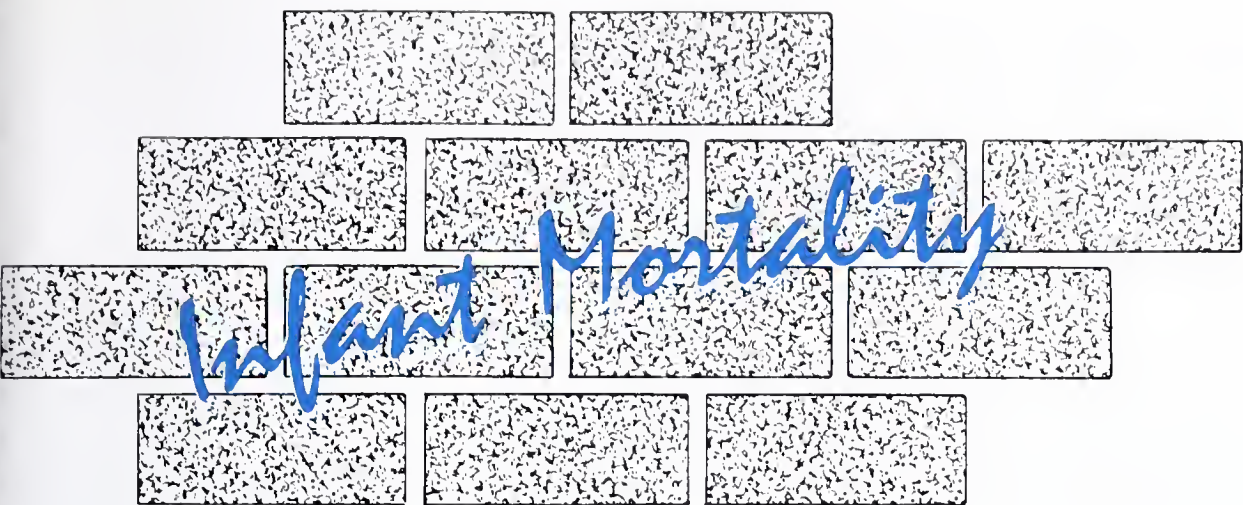
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By CONGRESSMAN RICHARD J. DURBIN

It is hard to believe that in some parts of Illinois, an industrial state in the most medically advanced nation on earth, there is a lack of resources to care for our children. It is also hard to comprehend that an infant born in a third world country like Jamaica or Trinidad has a greater chance of survival than a black baby born in Chicago or a child born in Pulaski County in downstate Illinois.

But it's true. Illinois ranks as one of the ten states nationwide with the highest infant death rate. It is for this reason that last fall I hosted two Congressional hearings in Springfield and Chicago addressing infant mortality in Illinois and pregnant women's access to prenatal care.

As a member of the U.S. House Select Committee on Children, Youth and Families, I requested the hearings in order to give other members of Congress a personal look at this crisis, and to hear from the state's medical community on ways to combat this tragic problem.

As a nation our infant death rate is shameful. According to the Chil-

dren's Defense Fund, the U.S. infant mortality ranking among twenty industrialized nations deteriorated from sixth in the 1950-55 period to nineteenth in 1980-85.

Illinois has made some progress in reducing infant mortality since 1978, but we have a long way to go to meet the U.S. Surgeon General's prescribed infant mortality reduction goal for the 50 states, a reduction to 9 deaths for every 1,000 live births nationwide by 1990. The most recent statistics from the Illinois Department of Public Health show 12 infant deaths for every 1,000 live births in Illinois (compared with 10.6 nationwide).

According to witnesses at our hearing, a lack of access to prenatal care is a contributing factor to this high rate. Approximately 11,000 low-income women in Illinois, many of them teenagers, receive little or no prenatal care each year. Without early, comprehensive care, pregnant women are three times more likely to deliver a low birthweight infant. In fact, testimony at our hearing concurred with a 1987 report by the *Illinois Times* saying

that many poor women in Illinois are having difficulty getting access to prenatal care.

The Illinois medical community is in a difficult situation for several reasons. As a result of a low Medicaid reimbursement rate for obstetricians in Illinois, many doctors are faced with a financial loss in treating a Medicaid patient. For example, the average cost charged by an Illinois doctor for prenatal care, including delivery, is about \$1,200 per mother. However, our state's Medicaid reimbursement rate for the same care is only \$447.

Illinois' reimbursement rate is well behind other states in the nation, including those with a high urban population. The reimbursement rate for Massachusetts is \$1,027; for Georgia, \$800; for California, \$721.68; and for New York, \$550. Illinois' Medicaid reimbursement rate is even lower than the overall national average of \$473.

Another growing problem for our state's obstetricians is the skyrocketing cost of medical malpractice insurance. One doctor in Illinois saw his malpractice premium

increase from \$37,000 annually to \$47,000 for six months. This obstetrician, in the prime of his career, had to seriously consider closing his practice.

His experience is hardly unique. Obstetricians have become especially vulnerable to lawsuits from

patients who sue after their babies are born at a low birthweight or with disabilities. As of 1985, 12.3% of OB/GYN's nationwide had given up obstetrics due to liability pressures. This is reducing the opportunities for adequate obstetrical care in many Illinois communities.

We must quickly work for solutions to these problems. To meet the Surgeon General's goal, the National Center for Health Statistics reports that Illinois will have to triple its current rate of progress by 1990.

What can we do to accomplish

Governor's Parents Too Soon Program Breaks New Ground

In 1983, Illinois became the first state in the nation to have a statewide program devoted to addressing the problems of teen pregnancy and teen parenting. Parents Too Soon (PTS) was formed by Governor James R. Thompson to coordinate and bolster existing services, and bridge the gaps between the providers.

In less than five years the program has attracted national attention. In recognition of his initiative, Governor Thompson was asked to chair the National Governor's Association Task Force on Teenage Pregnancy. And last year, Parents Too Soon received the 1987 Innovations in State and Local Government Award from the Ford Foundation and the John F. Kennedy School of Government at Harvard University. The honor comes with a \$100,000 grant to be used toward PTS programs.

"Children having children is not an acceptable concept," Thompson said when he accepted the award. "It leads to continued welfare dependency, poor health and other disadvantages for parent and child. The Parents Too Soon program has helped us to understand more fully the challenges of this issue and deal with them as effectively as possible."

Parents Too Soon is funded through three Illinois agencies—the departments of Public Health, Public Aid and Children

and Family Services. Those agencies coordinate teen pregnancy activities of seven other state agencies and advise 125 community based organizations which design and operate specific programs.

Participants on the community level have included local health departments, school districts, Urban Leagues, universities, hospitals and churches.

Their efforts pursue three goals: to reduce the incidence of teen pregnancy; to reduce the health risks of teen pregnancy; and to improve the teen parent's ability to cope with the responsibilities of parenthood.

Parents Too Soon Teen Hotline 1-800-4-CALL-US for information and referrals.

By the end of 1986, Parents Too Soon had helped more than 71,908 teen mothers through demonstration programs, prenatal care programs, parent training and the supplemental food program. Another 200,000 teens were reached through preventive measures such as education programs and leadership conferences. The Parents Too Soon hotline receives an average of 35 calls a day from teens with pregnancy or parenting problems.

Although the program is still very young, the results have been encouraging. In sheer numbers, births to teenagers dropped

11.9% from 1982 to 1985—from 25,013 to 22,043. The greatest decrease came in births to white teens, down 16.2%. The number of births to nonwhite teens dropped 5.8%. Some of the decreases can be attributed to a decline in the teen population, but there still was a decrease of 9% in births per 1,000 white teens.

The improvement also can be seen in the ratio of teen births to all births. In 1982, almost 14% of all births were to teen mothers. By 1984, births to teens accounted for 13% of all births. And by 1986, births to teens had dropped to 12.5% of all births.

However, much less encouraging are the figures for numbers of births to single teen parents. In 1982, almost 63% of all teen births were to single parents. In 1985, although the actual numbers had declined, the percentage of births to single teen moms had jumped to just over 70%.

The increase was seen in both white and nonwhite teen parents.

Family planning and education services (PTS does no abortion counseling or referrals), teen leadership conferences and an extensive public awareness campaign—including posters,

this goal? We must first take full advantage of existing resources. We are presently ignoring one cost-effective alternative: despite its eligibility, Illinois has not taken advantage of a program passed by Congress last year allowing states to expand Medicaid coverage to low-income pregnant women and young children. Governor Thompson, a member of the National Commission to Prevent Infant Mortality, should seriously consider the benefits that this expansion would provide to many low-income women in Illinois. Twenty-three states have already become participants in this program.

There are other existing programs benefiting Illinois that need our continued support. The Na-

tional Health Service Corps Program is a federal initiative which allows physicians to repay some of their medical school loans by devoting their skills to local community health centers in underserved areas. In fact, the NHSC is the largest supplier of clinic manpower to these health centers, which this year will serve over five million needy patients.

In recent years, the Reagan Administration has proposed eliminating the NHSC program. When you consider that community health centers serve thousands of low-income patients in Illinois (a majority of whom are on public assistance), it seems hardly cost-efficient to eliminate their source of manpower. It would mean that under-

served areas in Illinois would be left with only emergency services, and in some places no medical services at all.

There are also several cooperative efforts between our state's public health officials and the medical community. Two outstanding programs are the Parents Too Soon "Southern Seven" project in the state's southernmost counties, and the "Beethoven" project in Chicago.

The Parents Too Soon Program, which began in 1983 as an arm of the Illinois Department of Public Health aimed at reducing teenage pregnancy, focuses its "Southern Seven" program on providing transportation, education, medical and financial assistance to teen

public service announcements, a documentary and a highly successful teen songwriting contest—have been working toward reducing that number in the last few years.

Parents Too Soon programs aimed at improving chances of healthy babies and healthy mothers include a supplemental food program that reaches 25% of teen mothers, mostly in economically depressed areas of the state, and 30 prenatal care programs run by city or county public health departments. The program also funded three comprehensive demonstration programs and assisted four school health clinics.

One demonstration site was the Winnebago County Health Department. The year before the demonstration program began, 12% of the 500 babies born to teens that year were of low birth weight. Three years later, in 1986, the rate had dropped to 8.8%. The demonstration program reached 80% of the teens giving birth in the county.

To reach the third goal, improving the teen parent's abil-

ity to cope with the responsibilities of parenting, PTS programs focus on helping single teen parents (almost always mothers) avoid welfare dependency, preventing situations that can lead to delayed child development or child abuse, and reducing the likelihood of repeat cycles of teen pregnancy, parenthood and poverty.

A major program has been the Department of Public Aid's Young Parents Program, offering education, job training and basic skills development, as well as training in parenting, nutrition, personal and family health and improving self-concept.

Illinois is one of two states receiving federal funding for an expanded program for teen parents receiving Aid to Families with Dependent Children (AFDC). The new program, Project Advance, coordinates with Project Chance, the statewide program for job placement, and will target young fathers.

In the coming years Parents Too Soon will increase its outreach to teen fathers. The \$100,000 Innovations award

received last year will go toward male responsibility programs. The male effort started in 1986, with the establishment of the Illinois Male Adolescent Network, a resource of more than 60 agencies with male responsibility programs. Late last December, Governor Thompson announced that 13 agencies across Illinois had been awarded a total of \$253,000 to develop programs to teach responsibility to boys ages 10 to 15.

"Traditionally, teen pregnancy prevention programs have targeted adolescent girls," Thompson said in announcing the awards. "With this new funding, Parents Too Soon is taking an important step in acknowledging the boy's co-responsibility in the teen pregnancy problem."

Parents Too Soon also will continue to attack the problems of repeat pregnancy, education, job training and employment, and continued cooperation and communication between public and private agencies providing services to teens. ◀

mothers in the state's southernmost counties. The program has reduced the infant mortality rate for its teen clients to zero.

The "Beethoven" project, involving the Robert Taylor housing project on Chicago's south side, is a public-private effort headed by phi-

lanthropist Irving Harris which focuses on early intervention in the lives of disadvantaged young people. The program monitors health care for mothers and children from birth to kindergarten and beyond.

We must realize that these programs are an investment in reduc-

ing infant mortality, a problem too expensive to ignore. This year taxpayers will spend an estimated \$2 billion to care for low birthweight infants. In contrast, the approximate cost of delivering comprehensive prenatal care to all poor, pregnant women in the U.S. is about \$1

Illinois Attacks Infant Mortality Problem

In 1979, the United States Surgeon General established a national objective: to reduce the infant mortality rate to nine deaths per 1,000 births by the year 1990.

Illinois has been climbing toward that goal for the past 20 years. The state's infant mortality rate declined 28% from 1975 to 1985—from 18.4 to 11.6 deaths per 1,000 births.

Although closer to the "nine by '90" goal, more children die before their first birthday in this state than in any other northern industrialized state.

And consider:

- In 1987 there were 2,100 infant deaths in Illinois—200 more than the national average;
- Some 6% more babies are born with a low birth weight in Illinois than in the United States as a whole;
- The average underweight newborn spends 20 days in the hospital at an average cost of \$1,000 per day, often at public cost;
- One fifth of those low birth-weight babies are rehospitalized within a year;
- Illinois' postneonatal death

rate is 25% higher than the national average; half of those deaths are due to sudden infant death syndrome;

- The infant mortality rate for white children is close to that of whites in the U.S., but the infant mortality rate for blacks in Illinois is 20% higher than the national average;
- Infants born to teen mothers have a death rate 65% higher than infants born to mothers over age 20.

Faced with facts such as these despite years of progress, in 1985 Governor James Thompson stepped up the drive to reduce infant mortality with the state's first coordinated, comprehensive program to meet the Surgeon General's challenge. The Infant Mortality Reduction Initiative was renamed "Families With a Future", and program machinery warmed up.

Unfortunately, the long period of decline in the infant mortality rate seemed to hit a plateau in 1986, when the rate went back to 12.0 deaths per 1,000 births. Provisional figures for 1987 put the rate at 11.5.

Like the U.S. initiative, Illinois has a companion goal of 12.0

deaths per 1,000 births for non-white infants. The non-white rate was 20.0 in 1985 and 21.0 in 1986.

Even before 1985, Illinois had in place a network to insure the availability of perinatal care, prenatal care clinics in local health departments, a screening system for genetic diseases, public awareness and education campaigns, services to pregnant teens and teen parents, nutrition programs, service networking and more.

The Illinois State Medical Society presented a plaque to Governor James Thompson at the 1986 Annual Meeting in recognition of his progress in reducing the infant mortality rate in Illinois. The Governor received a further honor last year, when he was appointed to the National Commission to Prevent Infant Mortality. The commission holds hearings around the country to gather information on infant mortality and make recommendations to Congress and the President on ways to reduce and prevent infant mortality.

"Illinois has made enormous strides in reducing infant mortality, dropping from 18.4 to 11.6

billion.

On the federal level, Congress recently expanded optional Medicaid coverage to help low-income pregnant women. As a member of the House Budget Committee, I strongly supported "The Children's Initiative," a legislative package expanding several cost-effective programs benefiting children, as part of the 1988 Budget Resolution. I will fight to increase that funding level again in next year's budget.

On the state level, we must work

in a bipartisan, intergovernmental fashion to increase Medicaid reimbursement and resolve the malpractice dilemma facing obstetricians. We can also increase support for several state infant mortality projects, like the Parents Too Soon program.

Finally, at all levels, we must inform low-income women about the importance of prenatal care and where to get it. I am working with members of the state's medical community, the Illinois Congressional delegation, and state leaders in a

statewide effort to reach low-income mothers. We must move now to avoid the huge costs in medical care and human suffering that accompany high infant death rates. ◀

Congressman Richard J. Durbin of Springfield serves the 20th District in central western Illinois. A Democrat, Congressman Durbin is a member of the House Select Committee on Children, Youth, and Families, the Committee on Appropriations, and the Committee on the Budget.

deaths per 1,000 births in the years from 1975 to 1985," Thompson said before the first hearing. "We have done it with aggressive programs that combine all the assets and initiatives of both the private and public sector. But the problem is a dire one and we have a long way to go

through a network system. Clients are referred to Families With a Future by their doctors or other health care providers, agencies or programs, public awareness campaigns, a hotline number and other sources.

Case management is essential to the program. Case workers

trict, Vermilion County Health Department, Macon County Health Department, and Kankakee County Health Department.

In 1987, almost two-thirds of the public health budget—nearly \$120 million—was appropriated for programs for women and children, including Families With a Future. Other women and children programs dovetail with Families With a Future.

Among the complementary programs are Parents Too Soon, the Supplemental Food Program for Women, Infants and Children (WIC), Commodity Supplemental Food Program (CSFP), family planning services, maternal and child health block grants, and an adolescent health program.

Reaching the "nine by '90" goal will be difficult, but Illinois will not lower its sights. Dr. Bernard Turnock, Director of the Illinois Department of Public Health, said, "The goal itself is worth maintaining. It sets our sights quite high. The goal ties us into the national campaign, gives us a common bond and stimulates us to do as well as we can." ◀

Families With a Future 1-800-545-2200 hotline for information or referrals.

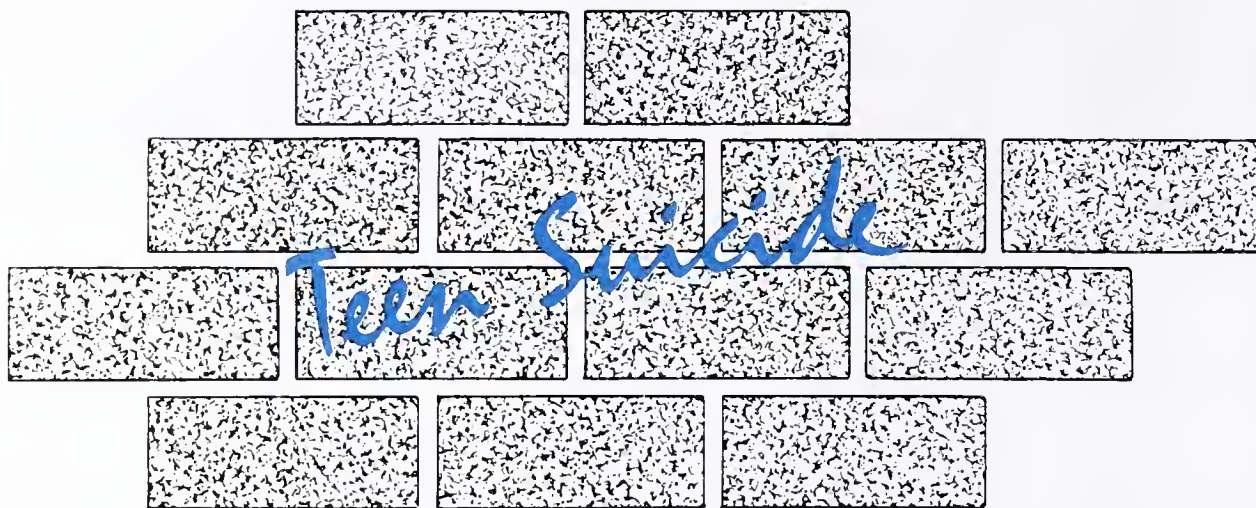
before reaching our goal of 9.0 deaths per 1,000 births by 1990."

The Illinois Department of Public Health oversees and funds Families With a Future with the cooperation of five other state agencies. In addition to money, the health department provides training, workshops and advice to lead agencies across the state.

The basic thrust of Families With a Future is to direct high risk pregnant women, infants and high risk women of child-bearing age to community based centers where they can be referred to services they need

ensure that all needed services are available to the family and that no mother or child "falls through the cracks."

Families With a Future augments and coordinates existing services and helps clients find services of which they otherwise may have been unaware. There are 27 networks, covering 19 Chicago communities and all or parts of 12 counties, areas of high infant mortality. They are overseen by seven lead agencies: the Chicago Department of Public Health, Cook County Department of Public Health, Southern Seven Health Department, East Side (East St. Louis) Health Dis-



BY FRED Z. WHITE, M.D., M.A.(Ed.), CHILLICOTHE, AND
JANET L. MYERS, R.N., F.P.N.C./PEORIA

The 1986 AMA White Paper on Adolescent Health estimates that 5,000 persons under age 19 commit suicide each year—and 50,000 attempt it. The American Academy of Pediatrics recently recommended that physicians ask about suicidal ideation in all adolescent medical examinations.

Last year, Peoria area community leaders formed a task force to study suicide. Working with staff from the Methodist Medical Center of Illinois, the task force formed a number of subcommittees to focus on specific aspects. A primary care physician/nurse subcommittee examined the phenomenon from the family practice standpoint. The subcommittee used two instruments—the Beck Depression Inventory and the Kovacs Childhood Depression Inventory—which may help to identify vulnerable teens and preteens.

A subcommittee of primary care family practice physicians and nurses agreed to assess the literature in youth suicide, examine its applicability to the local experience and identify some of the risk factors.

Suicide attempts occur when the life outlook is so despairing and hopeless that no other alternative appears viable. Some studies indicate a correlation between negative expectancies and seriousness of intent. Those with a history of underlying depression have been said to be most vulnerable. Some facts from the literature:

- Depression ranks in prevalence from third to tenth most common diagnosis encountered, and is the second most frequent psychiatric problem encountered.

- 50%-80% of patient visits to primary care physician offices feature a significant emotional component (and 54% of patient encounters occur in the primary care environment.)
- Up to 80% of those with moderate depressive symptoms seek medical care each year and of these, four out of five present to the primary care physician.
- Test instruments to identify depression greatly improve recognition.

It has been said that most individuals who attempt suicide have been seen within two weeks of the attempt in a physician's office. As a first step, the subcommittee did a quick, informal assessment of attempted and successful suicides in

one family physician's group practice.

Fourteen such patients were identified—five aged 23-62 and nine aged 15-22. All who had been seen were under treatment or had been referred to a psychiatrist. But six of those in the 15-22 age group had no prior visits or indications of early warning signs on the record.

The subcommittee determined that there were probably a fair number of at-risk children and that our task would be to find a means to identify them early on.

We decided to use the mandatory fifth and ninth grade physicals to screen patients for depression—and vulnerability to suicide.

Survey Findings

The pilot study was performed in the office of one group of family physicians. Preliminary results were exceedingly good. All questionnaires given to the children were filled out entirely by the children themselves. Many were completed in conjunction with a parent, but the children carried out the task in each case, indicating good acceptability and utilization.

The Kovacs Childhood Depression Inventory¹ was distributed to fifth grade students. The 27 questions center on the subject's emotional responses in a multiple choice format. Key indicators ask about suicidal ideation, social life and unspecified fearfulness.

Ninth graders were asked to

complete the Beck Depression Inventory.² Again, questions regarding friendships and suicidal ideation were found to be key.

Four of the children had been subjects of their parents' concern prior to the visit. In these cases, physician examination of the issue with the parent in the child's presence acted as a catalyst to appropriate professional counseling. The remaining five children found to be depressed through the instrument surfaced as a surprise to the parents (not the children). Again, referrals were made successfully.

Summary

The pilot study suggests excellent parental acceptance and good student utilization of survey instruments to assess suicidal vulnerability. Many questions remain. It is not known if the high level of acceptability will prove out on a broader survey sample.

Success of the ultimate preventive thrust must be studied over time. The University of Illinois Peoria School of Medicine's department of family practice is looking into a broader, long-term study. Physicians using these instruments and following their patients would be able to identify long term outcomes. A disturbing factor in the original study—that those youngsters who had been identified and referred for appropriate counseling and treatment continued to attempt or complete suicide—must be further examined.

Our results are very preliminary; a long term study with a larger volume of subjects is necessary before any conclusions can be drawn. It is certain, however, that this is an area which should be

ISMS Auxiliary Focuses on Teen Health

The Illinois State Medical Society Auxiliary has sponsored a number of programs around the state to help Illinois families work through problems with their teens. A September 1987 Adolescent Sexuality workshop for parents, physicians, school counselors, nurses and students drew strong support.

"The workshop sought to identify the growth and development needs of the adolescent," Lynn Kassel, ISMSA president, explained. "The speakers depicted

ted the process of adolescent sexual maturation and educated the audience on education, prevention and care of the pregnant adolescent."

Adolescent and family health issues are ongoing concerns of the ISMS Auxiliary. The adolescent sexuality workshop was videotaped and will be available for county auxiliary educational efforts. A teen suicide conference in September, 1985, was similarly designed to assist community health education efforts.

further addressed in assessing the mental and physical health of our young patients.

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Janet L. Myers, R.N., F.P.N.C., is a graduate of Methodist Hospital School of Nursing in Peoria, Illinois where she received her degree as a Registered Nurse. She, also

attended University of Illinois Peoria School of Medicine in Peoria, Illinois and received her certification as a Family Nurse Practitioner. She is an active member of the American Nurses Association, American Nurses Association Council Primary Health Care Nurse Practitioners, and Illinois State Nurses Association.

Fred Z. White, M.D., M.A.(Ed.) is a board certified family practitioner and fellow of the American Academy of Family Physicians. A professor of clinical family practice at the UI College of Medicine, Peoria, he is an adjunct professor of education at Bradley University. Dr. White, a past president of the Illinois State Medical Society, is chairman of the Board of Governors for the Illinois State Medical Inter-Insurance Exchange. He is a trustee for the Methodist Medical Center of Illinois, where he chairs the CME committee and serves as associate director for the family practice residency program.

Asking the Right Questions

Adolescence is generally defined as the years between ages 12 and 18, although it sometimes begins sooner and usually ends later. Developmentally, it is a time of testing social boundaries and experimentation. Physicians treating teens are likely to encounter problems associated with substance abuse and adolescent sexuality. The challenge in adolescent health care lies in maintaining focus on the teen as a young adult and family member faced with a number of hidden pressures, rather than a youngster displaying certain behaviors.

Richard G. Banta, M.D., is affiliated with SwedishAmerican, Rockford Memorial and St. Anthony hospitals in Rockford. A clinical associate professor of psychiatry at the UI Rockford School of Medicine, he is chairman of the medical advisory board for the Illinois Department of Alcoholism and Substance Abuse.

Banta feels that the physician needs to help parents recognize

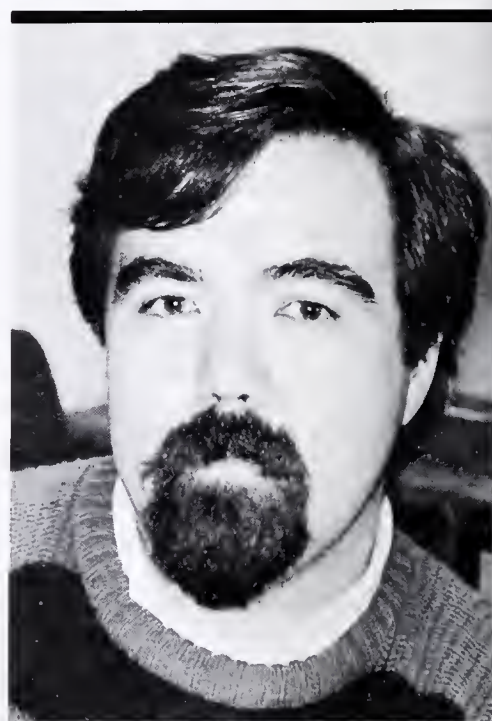
"We must do what we have been trained to do, and that is to do thorough histories and physicals which do not leave out certain aspects of the history or certain parts of the anatomy because we are uncomfortable with what is going on between the legs or between somebody's ears," says Dr. Tony Dekker. "The old rule in medicine is that if you don't take a temp, you can't find a fever. And if you don't look for pathology you aren't going to find it."

Anthony Dekker, D.O., is a family physician specializing in adolescent and young adult medicine. Dekker, the director of community medicine at Chicago Osteopathic Medical Center, works primarily with troubled teens. Medical director of the adolescent care unit at St. Elizabeth Hospital in Chicago, he is also affiliated with the pediatric ecology unit at Mt. Sinai Hospital.

Dekker completed an adolescent medicine fellowship at Rush-Presbyterian-St. Luke's Medical Center. He consults there and is on staff at Olympia Fields, Northwest Community and Holy Cross hospitals. He believes that strong families with genuine communication are the key to healthy adolescents.

"The vast majority of kids with behavior problems have communication problems with their parents," he says. "Lack of structure in the home, poor or negative environment with their peers, sexual activity or chemical activity—all of those things contribute. But if the physician is willing to accept as first premise the idea that the family unit is the patient when the child is the patient, he's two steps ahead."

Dr. Rick Banta would agree with that assessment. A child psychiatrist and diplomate of the American Board of Psychiatry and Neurology,



Anthony Dekker, D.O.

signs that their teens are troubled. "You ask about specific behavior," he says. "Has the kid started living a motel existence? In the last three months, he comes home, changes clothes and is gone again. He's totally isolated himself from the family. Has there been an abrupt change in personality? Is he significantly more moody?"

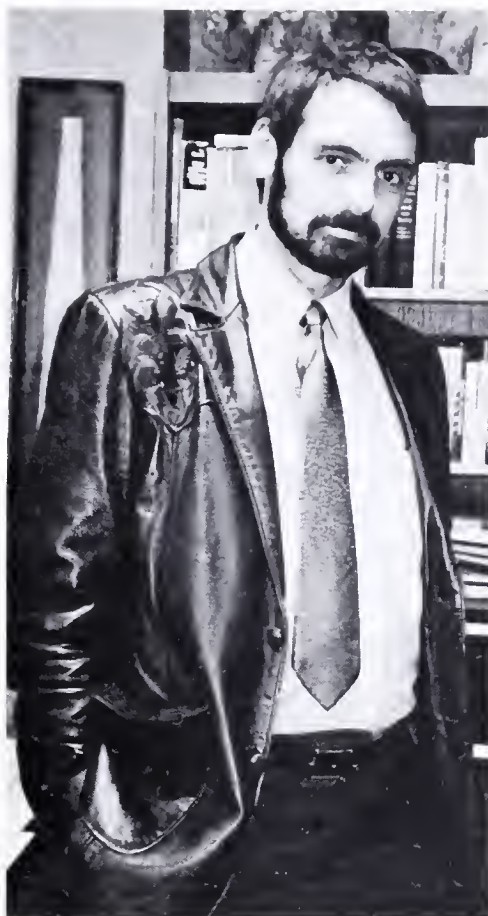
"What about his friends?" Banta continues. "Three years ago, he was slaving to be the starting quarterback. Now he doesn't even play football anymore. All he does is hang around the mall and play video games with those burnouts. His girlfriend looks like a real sleaze. You've tried not to say anything because you know what will happen if you do. But you have some real concerns about this girlfriend; you know that a year ago he would have picked someone different."

These observations can point in many directions. Dr. Violet Eggert suggests that physicians look for clues of adolescent substance abuse, and conduct the clinical interview accordingly.

Violet M. Eggert, M.D., is medical director of the Illinois State Medical Society Impaired Physician Program. Eggert is the former medical director for Interventions, a group of seven free-standing treatment centers for alcoholism, drug dependence, behavioral and emotional disorders. She chairs the ISMS ad hoc Committee on Training Physicians in Substance Abuse.

"According to the National Institute of Drug Abuse," Eggert says, "67% of all high school students have tried an illicit substance. Alcohol, marijuana and cocaine are the leading drugs of preference for teens, although inhalants, hallucinogens, stimulants, sedatives and over-the-counter drugs continue to be abused. The most frequently abused drug is alcohol: eight out of ten high school students have experimented with it."

"You can go through the yearbook for any high school in this state and find a page dedicated to the memory of someone who died because of a chemical event," Dekker says. "It might be alcohol or drugs directly, or it might be a drowning or accident that occurred as a result. We have to realize that it



Richard G. Banta, M.D.

mentation or knowledge of the effects of illicit substance abuse," she says. "I would suggest making a substance abuse history part of every office interview starting in preadolescent years. Both the patient and the physician become comfortable with the routine. It's important. Otherwise, the teen will probably sense your discomfort and evade the issue or mirror your uneasiness."

Substance Abuse: How Does It Start?

"Adolescents are torn between an increasing drive toward independence and the need to be part of a peer group," Eggert says. Teens may begin by abusing over-the-counter drugs because they are legal, cheap, available and easily concealed. Abusers love them because the high is quick and disappears fairly rapidly. Then they're attracted to psychedelics for the feeling of enhanced mental activity,

A chemically dependent kid who's on a detox unit is the angriest, saddest, most frightened kid you'd ever want to see. They've been desperately trying to be a real person and somebody has taken away their only source of security.

is the *usual* kid who uses illicit drugs before graduating from high school. Alcohol is the number one drug problem in our adult population—and over two-thirds of adolescent males will drink to intoxication during their senior year."

Establishing a Dialogue

Eggert stresses the importance of the therapeutic bond between physicians and adolescent patients, and the need to create an environment where they feel free to share their feelings and experiences.

"Physicians must be comfortable and nonjudgmental in questioning the teen about drug availability at school, drug and alcohol experi-

the novel perception of usual environmental stimuli and decreased ability to distinguish between themselves and their surroundings."

According to Banta, teens take drugs for the same reasons that adults do—to avoid confronting things. "A chemically dependent kid who's on a detox unit," he says, "is the angriest, saddest, most frightened kid you'd ever want to see. They've been desperately trying to be a real person and somebody has taken away their only source of security. The chemicals have bottled up the kid's rage, just as they do for an adult, but in addition to that, you're taking away the only way the kid has to face the world."

Children are exposed to drugs

Polydrug abusing teens tend to perceive life as a series of crises to which they react with agitation, malaise, hostility and aggression.

early, according to Eggert. "A typical drug use onset pattern begins at slightly more than 12 years of age for alcohol and about 13 years for marijuana," she says. "Usage may increase during the adolescent years and appears to peak in the early twenties."

Eggert points out that adolescent polydrug abusers suffer from lower self esteem, high levels of psychological distress, and lower perceived levels of parental control.

"Polydrug abusing teens tend to perceive life as a series of crises to which they react with agitation, malaise, hostility and aggression," she says. "And in households where a parent abuses alcohol, children often have a distorted view of what constitutes acceptable use of alcohol."

Alcohol: A Very Serious Drug

Banta drives home the dangers of alcohol for teens. "Alcoholism is a terminal illness," he says. "Once the average adult male becomes alcoholic, he's got 10 to 20 years of good drinking before he either hits bottom and gets well or dies. Women die quicker; an adult wom-



Violet M. Eggert, M.D. (Photo courtesy of The Pantagraph)

an has five to eight years."

"An alcoholic adolescent who has an opportunity for uninterrupted drinking will progress from onset of diagnosable alcoholism to either getting well or dying in anywhere from two to eighteen months."

"In most cases, uninterrupted drinking doesn't occur," he says. "The kid gets hospitalized because

nobody knows what's wrong but the kid is all screwed up, or parents really come down hard, so the drinking is interrupted."

Banta explains that while the diagnosis of alcoholism is no different in children than in adults, the definition is more subtle. "Technically, it's the same," he says. "It's the development of tolerance and loss of control. But we have to look at loss of control very carefully. Because of impulses and a whole bunch of other reasons, almost every 13-year-old who drinks three times is going to get drunk one of those three times."

"Chemical dependency is a terminal illness," he says. "If the parent doesn't want treatment for the child, it is reportable to the state as child abuse."

Risk Taking, Creativity and Chemical Dependency

"If you have a kid who is abusing drugs or alcohol," Banta says, "you need to find that which is special in him or her. You are going to engender activity in the direction of creativity. You are going to help them learn how to take positive risks."

Banta takes groups of his patients on camping trips and shows them how to climb mountain slopes. "A kid will listen more to other kids than to an adult. When I take kids rock climbing, I don't do much. I manage the ropes and make sure they don't break their necks. They do all the work."

"Next, you have to teach them that you don't have to hang off a

Substance Abuse Information

The Illinois State Medical Society coordinates a Substance Abuse Education Program for the membership. A self-directed learning packet, "The Physician's Role in Recognizing Substance Abuse," is available free of charge. A series of audio cassettes features common themes:

- Diagnosing Substance Abuse
- To Treat or Refer
- Conversations About Pedi-

atric Abuse: The Infant Victim

- Conversations on Prescription Drug Abuse
- Conversations on Cocaine.

Posters detailing signs, symptoms, toxicology and emergency treatment of substance abusers are available for physician offices. More information on these materials may be obtained by contacting the ISMS offices: (312-782-1654; or 1-800-782-ISMS).

The Illinois Department of Alcoholism and Substance Abuse publishes a resource manual on drug and alcohol treatment centers in Illinois. The manual is available free of charge by writing the Department at 100 W. Randolph, Suite 5-600, Chicago 60601. Their Springfield office is located at 222 S. College St., Springfield 62704. ◀

Commonly Abused Drugs— Some Diagnostic Clues

Substance abuse specialist Violet Eggert, M.D., suggests that physicians think in terms of specific signs and symptoms peculiar to commonly abused drugs when they examine adolescent patients for unexplained health problems. They should also be aware of the role of over-the-counter medications and other legally obtained substances.

Alcohol—Acne, enlarged pores and periorbital eruptions are commonly associated with alcohol abuse. Increased diaphoresis is another sign. Amenorrhea can be a secondary effect of alcohol (and other drugs) on the endocrine system.

Marijuana (Cannabis)—Conjunctival injection, malar flush and dry mouth indicate use within the last two hours. Sinusitis, bronchitis and pharyngitis are associated with social use. Existing pulmonary disease which exacerbates or is suddenly refractive to previously effective medication is also suspect.

Cocaine—Dilated pupils and fast pulse, unexplained chest pain, eroded teeth, and abnormalities in the nasal lining or mucosa are commonly seen in patients using cocaine. The adolescent may be restless and hyperalert, and report anxiety-like attacks. Increased

levels of suspiciousness or paranoia are common, as are aggressive or violent outbursts. Patients or their parents may report moodiness—alternating euphoria and depression. “If three or more of these signs are present,” Eggert says, “the physician should think cocaine.”

OTCs—Not all abused substances are illegal—or even harmful when taken under ordinary circumstances and in appropriate amounts. Physicians should be aware of the role of over-the-counter medicines in teen substance abuse.

Caffeinated substances are commonly abused by teens. Signs include insomnia, restlessness, excitement, tachycardia, tremor and diuresis. Nearly all sleep and cough preparations now contain antihistamine. Eggert quotes research by Victor, *et al.*, demonstrating that OTCs account for 7-10% of emergency cases, 2% of accidental deaths and almost 3% of suicides.

Inhalants—Eye irritation, photophobia, diplopia, and tinnitus are associated with use of inhalants. Nasal lining irritation, cough, nausea, emesis, diarrhea and vertigo are also common. Physical examination may

reveal cardiac irregularities as well as a peculiar odor on the breath.

Although the hobby industry has modified their products, adding an irritating scent and removing some toxic ingredients, teens continue to abuse aerosol propellants and industrial solvents. Typewriter correction fluid, toluene, lighter fluid, nail polish remover and fluorinated hydrocarbons are among the more popular inhalants.

Hallucinogens—Dilated pupils, increased body temperature, flushed face, fine tremor and elevated blood pressure are common signs of psychedelic intoxication. Spontaneous lateral nystagmus or lateral and vertical nystagmus in the absence of a diagnosed neurological disorder may suggest PCP (phencyclidine) intoxication. The most popular hallucinogens are marijuana, LSD (lysergic acid diethylamide) and, decreasingly, PCP.

Finally, Eggert cautions physicians to be aware of prescription drug abuse among teens who pilfer medications in the home or obtain them by other illicit means. While far less common among teens than adults, prescription drug abuse does exist.

rope to take a risk. Asking for a date is risky. Trying out for the school play is risky. Entering the swim meet is risky. Making a new friend is risky."

"You empower them and make them understand that they're special. All you're doing is meeting developmental needs."

**Emerging Sexuality:
A Major Issue**

Teens are growing up fast today—sexual maturation has accelerated significantly in the last

thirty years. Physicians need to approach the subject of sexuality earlier and anticipate hormonal shifts at a younger age than they themselves experienced.

According to Dekker, every complete physical includes a genital exam, and the direction of clinical inquiry flows from there.

"I know that it's possible to give a physical examination that proceeds directly from the belly button to the knees," he says. "The child gets a nonverbal message that this area is off limits. That shouldn't be. Again,

as physicians, we must do what we have been trained to do, and that means a complete history and physical."

"As part of the physical, you might ask a young male about genital pain. 'Have you ever been injured there? Have you ever had any discomfort? Have you ever had a girlfriend before? Have you ever had sex?'"

Dekker urges open-ended questions that require a response. "Ask if they are trying to have sex with anyone. If they say no, you have an

Number of Office Visits Made by Adolescents, by the 20 Most Frequent Principal Diagnoses for Visit: U.S., 1980-81

Age and principal diagnosis	Percent distribution	Age and principal diagnosis	Percent distribution
11-14 years		15-20 years	
Total (N = 40,269)	100.0	Total (N = 87,172)	100.0
General medical examination	7.0	Normal pregnancy	9.1
Allergic rhinitis	4.4	Diseases of sebaceous glands	8.4
Diseases of sebaceous glands ²	4.0	General medical examination	6.3
Acute pharyngitis	3.2	Acute pharyngitis	2.8
Acute upper respiratory infections of multiple or unspecified sites	3.2	Acute upper respiratory infections of multiple or unspecified sites	2.6
Suppurative and unspecified otitis media	2.9	Special investigations and examinations ⁴	2.0
Asthma	2.8	Disorders of refraction and accommodation	1.7
Disorders of refraction and accommodation	2.6	Allergic rhinitis	1.7
Routine infant or child health check	2.3	Other diseases due to viruses and chlamydiae	1.6
Certain adverse effects not elsewhere classified ³	2.0	Followup examination	1.5
Acute tonsillitis	2.0	Acute tonsillitis	1.4
Other diseases due to viruses and chlamydiae	1.9	Contact dermatitis and other eczema	1.3
Contact dermatitis and other eczema	1.7	Suppurative and unspecified otitis media	1.1
Fracture of radius and ulna	1.4	Contraceptive management	1.0
Disorders of external ear	1.3	Asthma	1.0
Curvature of spine	1.1	Disorders of menstruation and other abnormal bleeding from female genital tract	0.9
Bronchitis, not specified as acute or chronic	1.1	Bronchitis, not specified as acute or chronic	0.9
Observation and evaluation for suspected conditions	1.0	Disorders of external ear	0.8
Other noninfective gastroenteritis and colitis	1.0	Chronic sinusitis	0.8
Followup examination	1.0	Neurotic disorders	0.8
Residual	52.1	Residual	52.3

²Acne other than varioliformis

³Allergy unspecified

⁴Gynecological examination

(Source: U.S. Public Health Service and Health Care Financing Administration: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) DHHS Pub. No. (PHS) 80-1260. Public Health Service, Washington, U.S. Government Printing Office, Sept. 1980. Reprinted from "The AMA White Paper on Adolescent Health," 1986, by permission of the American Medical Association.)

opportunity to reinforce it. Say 'You're making the right decision. The longer you can wait, the better off you'll be. Having sex is very risky.' "

"The kid walks away with positive reinforcement and the physician has had the chance to let him know that he is old enough to get a girl pregnant, old enough to get a venereal disease. Since half of all teenagers have had some type of venereal disease by the time they are 18, it's worth intervening."

"The last step is, 'Listen, I'm really glad you aren't having sex, but if you ever change your mind and think that you are going to have to or want to, would you talk to your parents and come back to talk to me?' Keep the door open."

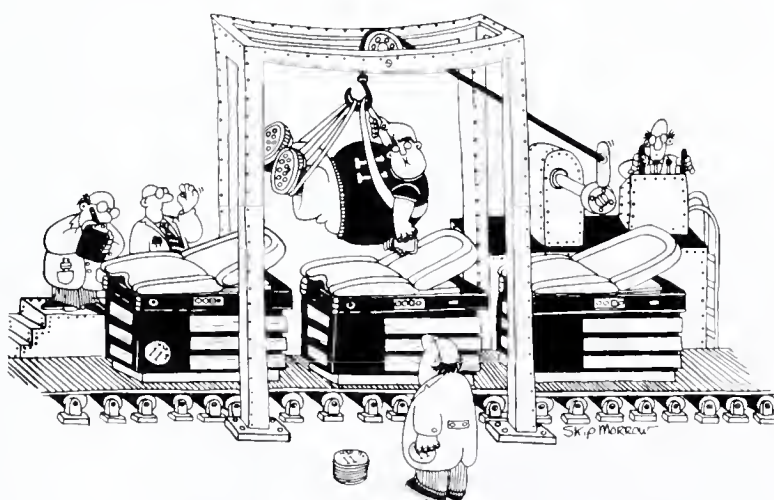
"Because of AIDS, it's a lot easier for physicians to talk to kids about sex now," Banta says. "Now they can say that abstinence is the best way to go and monogamy is the next best way to go. They can talk about values but make it sound medical."

Banta applauds the work of the Surgeon General in teaching kids about AIDS and particularly his videotapes for teens. He maintains a lending library for his patients with books and videotapes which give them a depth of knowledge on many subjects which their peers may not yet have. "We can talk about all sorts of things, and I can send them home with a Koop tape," he says. "They can hear about monogamy from him."

Just Say No

Physicians agree that a strong, consistent family structure, with straightforward, honest communication, builds healthy young adults. "Sure, we need to cater to their growing intellectualism, but the reality that is necessary is maintaining the authority line," Banta says. "I'm the parent, you are the kid—that isn't negotiable."

"If children have consistent care all the way through adolescence, they'll be able to make that jettison into society and survive," Dekker concludes. "If you're too protective, the world will eat them up. If you're not protective enough, they'll fall too many times, and eventually, they won't want to get up."



Inspected by Number 11.



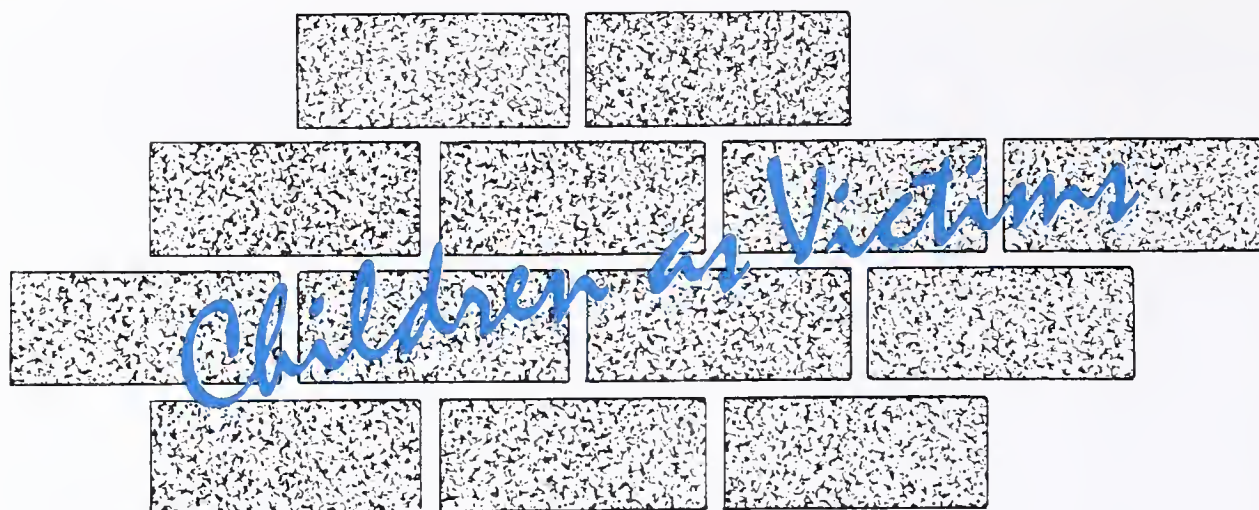
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Abused and neglected children display a number of diagnostic clues. The physician's task is two-fold: to intervene and report suspected abuse and to help the child rebuild self-esteem.

A sympathetic interview which considers the total developmental picture is essential when abuse is suspected. This article gives a snapshot composite of pressures facing children raised in abusive environments and the tragic outcome when their only escape is to run away.

Last month, the Illinois Department of Children and Family Services announced that 92,000 calls had been logged on the Child Abuse Hotline in 1987. About half of these reports prove to be true—and child abuse is grossly underreported.

Child abuse most often involves non-accidental trauma—fractures, burns, bruises, welts, cuts and internal injuries. According to the 1986 “White Paper on Adolescent Health,” published by the American Medical Association (AMA), more than one million children under 18 suffer such abuse each year. Many of the same victims suffer also from neglect: failure to receive adequate food, shelter, clothing, medical care, supervision, affection, intellectual encouragement and social stimulation.

Sharon Ahart, M.D., a board certified pediatrician, is director of the

division of pediatric ecology at Mt. Sinai Hospital in Chicago. The ecology unit admits children up to age 16 for a five day stay. While most have been victims of physical or sexual abuse, some with unexplained behavior disorders are also admitted.

Referrals come from the Department of Children and Family Services (DCFS), police and emergency room personnel. It's a medical unit with psychiatric, medical and pediatric staff. “We look at the entire composite of the child,” Ahart said. “The psychological aspect, the interview, the history, the physical examination and the behavior.”

Establishing A Context

“If you are working with children and teens, it takes a long time to get some social history,” Ahart maintains. “You need one; you can't find

out what's going on with the child unless you do it. A lot of teens in behavior or discipline classes are there because of problems at home that haven't been identified. That's reflected in their behavior.”

Heriberto Torres, M.D., is a fellow in the pediatric ecology unit at Mt. Sinai. A pediatrician specializing in adolescent health, Torres described interview techniques for victimized young persons. “One or a combination of tests may be used, depending on age and modality chosen,” he said. “One is a see-through plastic doll to mimic the situation going on at home. The other is an anatomical doll to let the child recount the story. The third is a coloring book called ‘Children Don't Lie’, which uses animal characters and pictures.”

Ahart tries to bring the victim's family into treatment. “We don't allow the sexual perpetrators to live in with the children, but we do allow parents to live in, as well as siblings. We need to look at the family.”

Not all parents cooperate. “We don't get as many parent participants as we'd like,” Ahart said. “A lot of times the kids are abandoned. I begged a 22-year-old mother with four children to stay while we evaluated one child who was already in foster care. She said ‘Let me go get some clothes and I'll be back.’ I knew when she left that she wasn't

coming back.”

Ahart stressed the importance of early intervention. “If we identify problems early, we have a much better chance of having healthier adults,” she said. “It’s very hard to change behavior or to intervene where there has been trauma at a young age, or continuous trauma to the child throughout life.”

According to the AMA, six percent of boys and fifteen percent of girls experience sexual abuse before they reach the age of 16. One-time abuse is less traumatic than repeated abuse. Half of all rape victims—and 40% of all perpetrators—are under 18.

At Their Wit’s End: Runaways

“Running can be a survival skill for the child,” Ahart maintains. “In any relationship where you are harassed day in and day out, you eventually say, this is enough. It’s all I can take. And you run. An adult just switches jobs or leaves, but children—and teens are still children—really aren’t in charge of their lives yet. They can’t just go out, get a job, and move out of the house. We have no safe houses for these kids to go to when they have problems. So where do they go? The streets.”

The AMA reports that about half of all runaway children were seriously abused at home. In many cases, running away is the only escape. Between 500,000 and one million teens run away from home each year in the U.S. Their mean age is 15 years, and most are white suburban adolescents. While 72% return within three days, six percent are never seen again. The federal Department of Health and Human Services Runaway and Homeless Youth Program funds some shelters for abused and runaway adolescents. Ahart believes that many more such support facilities are needed.

“We need safe houses, so they don’t get into drugs and they don’t get into prostitution and pornography. A place where they can go, they can be evaluated, they can have counselors, they can continue with school, they can start therapy and begin to rebuild their self-esteem. Kids need advocates. They don’t pay taxes. In our society, kids don’t

The AMA reports that about half of all runaway children were seriously abused at home. In many cases, running away is the only escape.

vote so they don’t count. We need to make people understand that they do count.”

Do runaway children fit their street-smart image, or are they vulnerable to further victimization when they leave home? Anthony Dekker, D.O., a family physician specializing in adolescent and young adult medicine, sees a lot of vulnerability. Dekker, the director of community medicine at Chicago Osteopathic Medical Center, works primarily with troubled teens. Medical director of the adolescent care unit at St. Elizabeth Hospital in Chicago, he is also affiliated with the pediatric ecology unit at Mt. Sinai.

“In the city of Chicago on any given summer night, there are at least 2,000 teenagers on the streets,” Dekker says. “According to the Chicago Police Department, many of these teenagers are not residents of Chicago, or even Illinois. They’re from Michigan, Indiana, Wisconsin and Minnesota.”

He echoes a common theme. “The key here is for people to realize that teenagers who are sexually abused have very poor self esteem. As a result, they see their bodies as a medium to get what they want—if money is what they want, they are going to use their bodies to get money. If it’s drugs, they use their bodies to get drugs.”

Ahart’s comments are consistent: “They don’t know anybody. They’re victimized. Sexual abuse can start in infancy in incestuous relationships. It’s usually a chronic thing. So they’ve developed a victim-type personality. Then they go out on the streets and they’re victimized and abused. When the pornographers and such are done with them, they use them to get other kids involved.”

“Just because a teenager is sexually active doesn’t mean she hasn’t

Epidemiology of Runaways

1. **Incidence:** Approximately 500,000 to 1 million adolescents run away each year
2. **Age:** Mean age is 15 years, with almost all runaways between 14 and 17 years old
3. **Race:** A majority of runaways are white suburban adolescents
4. **Length of time away from home:**
Less than 3 days: 72%
Four to 14 days: 15%
More than 14 days: 13%
5. **Return behavior**
Return home on their own: 50%
Return home through parental or peer involvement: 30%
Return home through police intervention: 14%
Never return home: 6%

(Source: “The AMA White Paper on Adolescent Health,” 1986. Reprinted with permission of the American Medical Association.)

been sexually abused or isn’t being abused,” Ahart says. “Teen runaways who’ve been involved in pornography will tell you. Why did they take off from home? Because their father, or whoever, was doing this to them. But where do they run? They have no place to go.”

According to Dekker, some children exhibit promiscuous behavior because they don’t know how to form ordinary friendships. “These children, these 15, 16, and 17-year-olds, are absolutely needy for any type of emotional contact,” Dekker says. “Sex is something where they feel accepted, and many of my patients who’ve been sexually exploited admit that they really want the closeness and intimacy that presexual activity includes—the foreplay, the touching and the talking and the sharing. They are

willing to be exploited sexually to get it.”

Dekker offers some statistics from the Society for Adolescent Medicine. “At any one time, there are 100,000 adolescent male prostitutes and 200,000 female adolescent prostitutes. There are only 20 million teenagers in this country. That’s a significant part of the population.”

Stepping In: A Team Effort

Troubled adolescents are likely to exhibit certain behaviors. Ahart gives a quick laundry list. “You have attempted suicide. You have kids with no self-esteem who don’t want

to take a bath, don’t want to get up. Major depression is not unusual in teenagers. You have acting out behavior, because their trust in adults has totally dwindled away. You have robbing, stealing, acting out at school, sexual promiscuity.”

“The doctor must be sensitive to any behavior disturbance in an adolescent,” Torres states. “It can indicate not only sexual or other abuse, but other changes the physician should be aware of. If a child is depressed, doesn’t hold her head up, shows low self esteem, has difficulty making friends, he or she is telling you something. If a child is suddenly urinating on himself or

not using good hygiene, there’s a reason.”

According to Dekker, effective intervention is a team effort. He urges that physicians seek support from adolescent health physicians and social service personnel. Teachers, school nurses, psychology and social work staff can contribute. Absent intervention, he warns, the problems will only intensify. “What will happen is the teenager will do another acting out behavior—run away further, run away longer, do something to hurt himself. Nobody in the system has to do everything,” he concludes. “But everybody has to know where all the pieces lie.” ◀

Reporting: The Legal Mandate

If abuse or neglect is suspected, physicians are mandated by law to report the case to the Illinois Department of Children and Family Services hotline. Normal physician-patient confidentiality privileges do not apply; in fact, failure to report suspected abuse or neglect is grounds for license revocation or discipline. The Department maintains a 24-hour toll-free hotline number (1-800-25ABUSE) for this purpose.

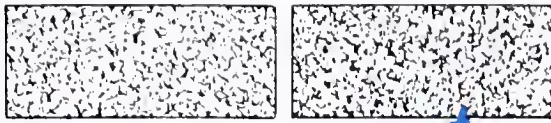
The reporting physician should be prepared to communicate the child’s name and address, and his or her parents/guardians; the child’s age; the nature of the child’s condition, including evidence of previous trauma or disability and any other information which might help to establish the cause of the abuse or neglect and the identity of the responsible person. A written report is required within 48 hours of the immediate telephone call.

The ISMS Ad Hoc Committee on Child Abuse Education has produced a booklet to help physicians identify victimized patients and intervene. “Child Abuse and Neglect: The Physician’s Role,” gives diagnostic criteria, interview guidelines, treatment concerns, reporting information and resource lists. It’s available from the ISMS offices (312-782-1654; or 1-800-782-ISMS).

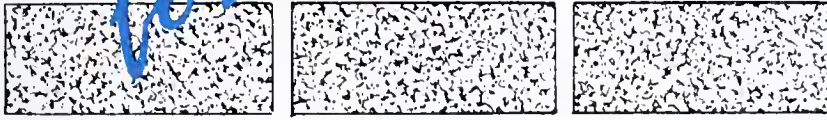
If the immediate safety or well being of a child appears to be endangered—or if the family may flee or the child disappear—a DCFS Child Protective Service Unit must commence an immediate investigation, regardless of the time of day. (In such cases, the physician should make it clear at the time of the report that the child is present in his/her office.) In all other cases, investigation must begin within 24 hours, and a determination is mandated within 60 days.

Heriberto Torres, M.D., believes that, ideally, physicians should fulfill their legal obligation to report suspected abuse without violating the patient’s trust. “The parent and the child have to know that you are making the report,” he says. “It’s very simple. There is a loyalty between the physician and the patient. If there is a problem, I must tell you that I’m going to report it and explain why.”

If the child is afraid to let others know about the abuse, Sharon Ahart, M.D., suggests a firm but gentle hand. “You have to sit down and tell them that, as much as it’s going to cause some problems in the family right now, they can’t be continuously victimized. It is not their total responsibility to hold the family together by letting the abuse continue. You have to explain that when you are an adult and you abuse a child, that is a misuse of power.” ◀



Time out
for a
Checkup



Is the current generation of teens less physically fit than their counterparts of years gone by? Does school-based physical education do the job? What about the dangers of overcompetitiveness in scholastic sports programs? IMJ asked three Illinois experts in sports medicine to assess the fitness of today's youth.

"The majority of kids still want to 'blow off' gym class," laments Daniel T. Davison, D.O., a board-certified family medicine specialist and graduate of a two-year fellowship program in adolescent and young adult medicine at Chicago's Rush-Presbyterian-St. Luke's Hospital. His special expertise is sports medicine, "the total care of individuals who are involved in recreational activities, organized sports and professional, elite athletic regimens."

The emphasis is on *total care*, which is the reason why Davison worries about today's teens' lack of interest in physical fitness. For most kids, physical fitness is a social experience, he explains. In fact, a gym class grade is one way he uses to measure a kid's social adaptability. "It's pretty hard to flunk gym," he asserts, "which is why it's a good indicator of an adolescent's social functioning."

Are Kids Out of Shape?

"The bottom line is that most kids today are out of shape, as defined by their aerobic, cardiovascular condition," according to

Davison. Part of the reason is that schools, hard pressed for dollars, squeeze down or try totally to eliminate physical education programs. "Physical education and interscholastic athletics are the first to feel the pinch of shrinking resources," advises Robert C. Hamilton, M.D., a board-certified orthopedic surgeon and former Illinois State Medical Society president. While Hamilton says that the student athletes he comes in contact with are, if anything, better trained than ever before, he echoes Davison's sentiments that general adolescent fitness may be on the decline. According to Hamilton, some grammar and high schools have cut back physical education classes from five to three days a week. Only Illinois state law prevents their elimination entirely (see accompanying story on page 188).

Contrasting this urban view of teen fitness shortfalls is Dr. James Reid, a family practitioner and one of two physicians serving the southwestern Illinois town of Greenfield (population 1,100, with 250 students). In his 24 years of practice in

Greenfield, Reid has not detected a deterioration in the fitness level of local teens. "It may even be slightly better than ever," he says. He attributes the rise to "a very active sports program emphasizing physical fitness at all levels."

"We start with pee wees in the fifth and sixth grades in basketball and volleyball programs," Reid says. He believes an active, continuing school physical education curriculum is vital to kids' physical fitness and development.

But are school athletics the best exercise regimen for out-of-shape teens? Our three physicians all believe that doctors who see teen patients needing exercise or overall fitness improvement should push for participation in school sports. "The benefits are not merely physical fitness, but camaraderie and learning how to be a team player—all important values for a teen's ability to function later in life," says Davison.

Striving to Win

The problem, however, is that overemphasis on winning can lead to psychological problems and emotional fatigue—especially for out-of-shape adolescents. "Overcompetitiveness can discourage those who aren't stars—and who most need structured physical education," Hamilton says. "We have to

learn to reach the largest percentage of teens who are not interscholastic athletes," he continues. "Only 10% of boys and a lesser percentage of girls are usually involved in formal interscholastic athletics. There must be physical education and intramural programs available for all students—and encouragement by teachers, parents and family physicians that it is important to participate."

Reid also worries about the tendency of even elementary school programs to stress winning so much. "It bothers me when a fifth or sixth grader who can hardly hit the backboard with a basketball is striving so hard to win," he says. Coaches must resist the impulse always to "play the five best players and leave the slow growers sitting on the bench," he warns. "They should be learning how to play rather than just out for another win." Reid believes that such overcompetitiveness shows effects at the 11th and 12th grade levels. "Our high school basketball program this year shows it. Some kids are not trying out for the team. There's some element of burnout."

Davison recommends that a teen fitness regimen should emulate that of adults. "It's important," he says "that physicians let teen patients know that it's more important for building body structure to get some type of exercise three or four times weekly, than to worry about being 'jock number one.'"

Tackling the "Couch Potato" Mentality

Despite efforts by physicians, parents, schools and even the media's current fitness fascination, only 36% of teens are able to pass basic physical fitness tests. Conducted by the Amateur Athletic Union, the study measured fitness in youths aged 6 through 17 during the 1983-84 school year. The 36% who met test standards, designated by the AAU as "achievable by the average healthy youngster," represented a decrease from 43% of those who achieved the standard in 1979-1982 tests. There were no major differences in scores between inner city, suburban and rural youth.

One big problem in teens today



Robert C. Hamilton, M.D.

in changing chronic adolescent behavior—be it weight loss or catalyzing involvement in a fitness program—without a motivated parent to help."

Another trouble sign which alerts doctors that teens are out of shape is an unabating run of common illnesses. "If you've got a kid that's not getting good nutrition at home, they'll start showing up with illnesses that are too common . . . too many colds, poor color, unhealthy-looking skin. That's malnutrition—the reverse of obesity," explains Reid.

Using Physicals to Spot Trouble Signs

Regularly scheduled physicals are mandated by Illinois state law for kindergarten, fifth and ninth grades, and every year for youths participating in sports programs.

Physical education and interscholastic athletics are the first to feel the pinch of shrinking resources.

which may cause or contribute to ill-fitness is obesity. Says orthopedist Hamilton, "We're in the middle of a 'couch potato' society, as opposed to a 'doing' society. I'm talking about parents' habits, which naturally filter down to children."

Davison usually begins tackling a young patient's weight problem by checking cholesterol levels. "It's not uncommon to see elevated cholesterol levels in young people," he says. He uses the reading to explain the importance of proper nutrition and exercise to adolescent patients. "And if I see that a parent and a child are both overweight, I try to encourage them to lose weight together. It's easier to accomplish using a 'buddy system.'"

But it can be difficult, according to Reid, to motivate obese teens to exercise. "They go two laps and are out of breath." That makes it all the more important that their physician works with them to develop a practical, incremental exercise and diet program which will work over the long term. But Davison adds a warning: "You can't be successful

They provide an important avenue for doctors to search out clues on the youth's *total* fitness and well-being.

For instance, Davison "takes advantage of the time in preseason physicals to talk about some things that don't usually come up—such as sexual activity." He's found that "there is about a 60 percent incidence of sexual activity in both suburban and urban athletes." "Because of the likelihood that they're not using anything to protect themselves, I think it's appropriate to counsel them on basic family planning."

Dr. Hamilton believes that doctors examining teens—especially adolescents preparing to embark on a season of sports activities—should be especially on the lookout for areas of atrophy or weakness, excessive or limited range of motion in joints and previous history of musculoskeletal or neurological injury. "The primary physician concerned about ill fitness or other ailments in adolescents should readily refer to a specialist for eval-

uation—especially on the question of whether or not the patient is fit to participate in a sports regimen,” he adds.

Too Much of a Good Thing

What about adolescents who are active and enthusiastic participants in fitness programs? Too much of a good thing can also injure their health, according to the physicians interviewed here. “Unfortunately, adolescents don’t often know how to listen to their bodies well,” says Davison. “If it hurts, then you’re not ready to go back to a sport, and you shouldn’t be using the given body part that’s injured.” Dr. Reid warns of the dangers of competitive weight lifting among teen athletes. “Without supervision they tend to try and lift heavier and heavier loads.” Echoes Davison, “There’s a great potential for harm when unsupervised teens are out to prove how much they can lift in a given time.”

The result of such unsupervised competitiveness can be injury of the epiphyseal growth plates which are still open and developing. “It’s not uncommon to see significant ligament injuries in young athletes—especially those involved in contact sports,” Davison adds. And long distance running in young people should be carefully monitored, according to family practitioner Reid. “A prepubescent youngster

running marathons is troubling, because the legs take a terrible pounding which could injure the growth centers there.”

While many teens take the time for proper body building and conditioning, others use drugs to boost their strength. Yet, the secret use of steroids by teen athletes has been “overblown,” according to Hamilton. In the early 1980s, they may have been used more extensively, but today he sees only “isolated cases.” Yet, physicians must be prepared to spot suspicious growth in adolescents: “If a 14 or 15 year old boy has gone from 120 to 180 pounds in a year’s time without corresponding bone growth, he might be suspect.”

However, if a youth is using only small doses of steroids, it might be hard to detect, according to Davison. “They really work hard at hiding it because if found out they’re off the team at most high school and college levels.” When he does a preseason physical and gets a positive indication, he confronts the patient. According to Davison, some additional signs of steroid use are smaller than expected testicles, rapid change in body build and personality alterations. “The problem is really one of substance abuse,” he assesses. “You’ll usually see lifestyle changes accompanying steroid use, such as a drop in grades, missing money, changes in

Youth Fitness Facts

The President’s Council on Physical Fitness and Sports indicates that:

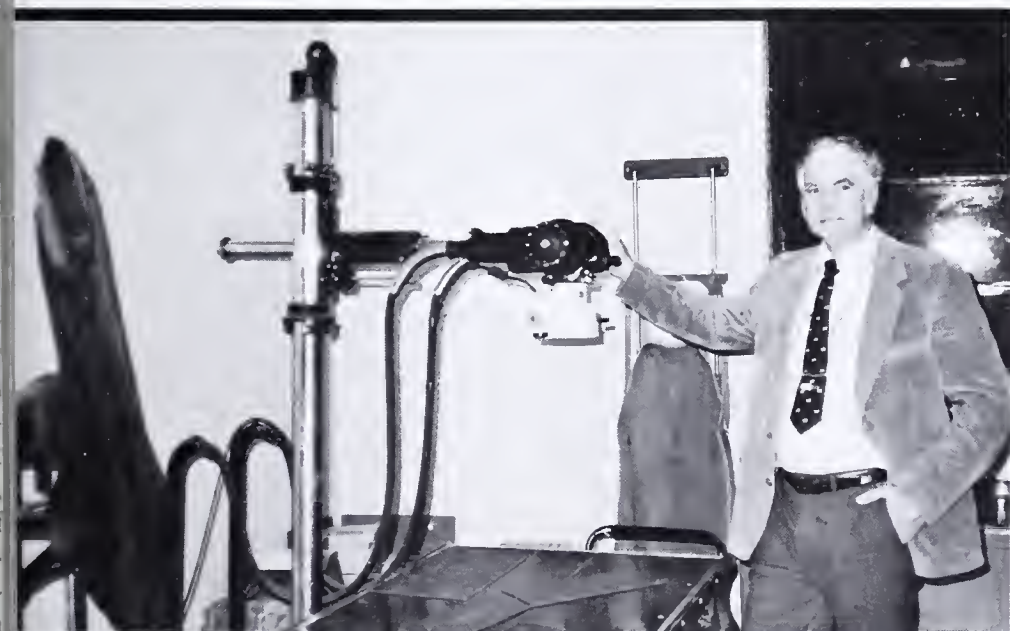
- More than half the nation’s schools do not have physical fitness testing.
- Forty percent of boys age 6 through 12 cannot do more than one pull-up; the same is true for 70% of girls age 6-17.
- One-third of boys age 6 through 12 and 50% of girls cannot run a mile in less than 10 minutes.

A 1984 U.S. Department of Health and Human Services study showed that:

- Only 36% of students in grades 5 through 12 have physical education daily.
- Most children in grade school take P.E. classes just one or two days a week.
- High school juniors and seniors have the lowest enrollment rates in P.E. classes.

Here’s how Illinois stacks up according to the 1986-87 American Alliance for Health, Physical Education, Recreation & Dance Survey:

- Only Illinois, New Jersey, New York and Rhode Island require students to take physical education for a specific amount of time from kindergarten through 12th grade.
- Illinois is the only state which requires students in all grades to take physical education every day.
- Illinois, Louisiana and California have the highest physical education requirements, in total number of minutes, per student career.



James C. Reid, M.D., of Greenfield, Illinois, and his 1942 x-ray machine, which enables injured athletes to be x-rayed in his office rather than fifteen miles away at the nearest hospital.

other life relationships.”

Preventing Injuries on the Playing Field

The most common injury in teen-aged athletes? A sprained ankle, according to Drs. Hamilton and Reid. But as the old adage goes, an ounce of prevention is worth a pound of cure. And each of the three sports medicine experts interviewed here has preventive recommendations for keeping teen athletes healthy. While focusing on organized and scholastic-sponsored sports, the recommendations certainly apply in some form as well to neighborhood “pick-up” games.

Proper equipment is the first necessity. “Improvement in equipment over the years has been very good,” according to Greenfield’s Reid. “It’s much lighter, and much stronger.” But Davison worries that school athletic programs may not use sufficiently effective protective gear—especially in underprivileged neighborhood public schools. “Equipment is used over and over again, and not necessarily reconditioned as it should be.” Parents should also keep an eye on their childrens’ equipment. Worn

Unfortunately, adolescents don’t often know how to listen to their bodies well. If it hurts, then you’re not ready to go back to a sport, and you shouldn’t be using the given body part that’s injured.

out athletic shoes or broken equipment certainly can cause injury. “Hand-me-down” equipment must be carefully fitted to the individual athlete or it won’t be effective.

Another key component of loss prevention on the field is “fitness and conditioning of the athletes,” according to Hamilton. “For many years, sports medicine activists have advocated the presence of a certified athletic trainer in secondary schools. Only 10 percent of high school athletic programs have them,” he explains. “This means that the prevention—the taping and the athletic training duties—are delegated to a junior coach who may know little about athletic training.”

Hamilton believes that the great-

est cause of athletic injuries stems from “lack of proper preseason, in-season and between season conditioning programs and the absence of a trainer.” The presence of a team physician just isn’t enough in Hamilton’s view. “We can’t be there all the time for first aid, taping and other preventive activities during practice sessions and before games.”

Davison laments the loss of just such an athletic trainer that his hospital’s program used to help school coaches. “One of his functions was to instruct the coaches on whether a piece of equipment is still safe for use.” A replacement is being recruited because, in Davison’s view, “the program has suffered without a trainer.”

Illinois’ Physical Education Law Faces Pocketbook Pressure

According to experts, Illinois’ physical education law may be one of the best in the nation. But it doesn’t necessarily follow that Illinois kids are the most physically fit. That’s because school authorities, faced with ongoing pressure to do more with less resources, often view physical education as a place to cut back. In recent years, the law has faced a variety of challenges by state lawmakers and regulators to “water down” or entirely eliminate it.

Although the law has managed to survive, it allows flexibility for “exceptions.” In some grades,

physical education classes may be replaced by health education courses. High school juniors and seniors participating in interscholastic athletic programs can be excused from gym requirements. There is also an out for 11th and 12th grade pupils who “enroll in academic classes which are required for admission to an institution of higher learning... or for graduation from high school.”

What *does* Illinois’ physical education law require? “Pupils enrolled in public schools and state universities engaged in preparing teachers, shall... be re-

quired to engage daily during the school day, in courses of physical education for such periods as are compatible with the optimum growth and development needs of individuals at the various age levels.”

The bottom line: there is some guarantee that most kids in Illinois grammar and high schools will get their adrenaline flowing during the daily school curriculum. While that’s not by any measure equal to being physically fit, it does expose youths to the benefits of a regular exercise program. ◀

Strong Supervision and Discipline

All three physicians stress strong supervision for effective and health-wise adolescent fitness programs. "The discipline of athletics is a very positive influence on the lives of young boys and girls," remarks Hamilton. "In the inner city, it's often the medium of athletics which motivates adolescents to complete high school and earn a scholarship to continue on."

Discipline is just as important an element of school athletics in rural Illinois. Says Reid, "The coaching staff and school community at large must back disciplinary action. We absolutely lost two games this season because of suspensions due to alcohol abuse. We made it stick."

Drs. Reid, Hamilton and Davison speak from experience. Each has worked with athletic teams—ranging from grammar and high school to college and professional sports

organizations (see accompanying story below). To each, sports medicine is an avocation as well as a medical specialty. For adolescents, these doctors believe, good fitness habits are important preludes to later lifestyles. Making physical education safer, more practical, and a little more palatable to teens is their ultimate goal. ◀

Meet the Team . . . Physicians

Robert C. Hamilton, M.D., a board-certified orthopedic surgeon, serves as team physician for the DePaul University Blue Demons, a nationally recognized college basketball team accustomed to being a championship contender. Hamilton was instrumental in establishing the Illinois State Medical Society's team physician awards program. Over the years, he has served Gordon Tech and many other Chicago area high schools and the University of Illinois' athletic program.

"There are two types of young people who come to a physician's office for a regular examination: those who want eligibility to play and those who are looking for a physician's excuse as a way to avoid physical education, perhaps in favor of another study hall or early release from school. It's incumbent upon physicians taking care of young people to recognize the 'avoiders' and to educate them about the benefits of physical fitness on health and enjoyment of life in general."

He urges colleagues to "try out" serving as a team physician. "In Illinois, we have many, many dedicated physicians who have helped local high and junior high schools—usually without compensation."

Daniel T. Davison, D.O., a board-certified family medicine specialist, is part of the sports

medicine program at Chicago Osteopathic Medical Center. "We recognize that many high schools around here are underserved. We take care of about eight or nine, providing preseason physicals, counseling, coverage of athletic events and injury prevention." The program uses medical residents to assist, "and there is some money available from the city to reimburse physicians or residents covering athletic events."

"Surprisingly, we've found that team athletic medicine seems to be very low risk. I'm not aware of a medical malpractice lawsuit that's ever occurred here resulting from game coverage at the high school level."

Dr. Davison attributes his success in working with teens to "respecting the young person's confidence. I tell young people that what they tell me will stay in the room unless three things may happen: they are going to harm themselves, harm someone else, or they prove that they are unable to meet their basic needs. For example, if they are abusing steroids then they are not meeting their own basic needs as far as I am concerned."

James C. Reid, M.D., a board-certified family medicine specialist, is the team physician for Greenfield Community High School, as well as for the local grammar and junior high physi-

cal education and sports programs. He also previously served college level athletics at Illinois College, Jacksonville. In 1987, he won the Illinois State Medical Society's Team Physician Award.

"I have no contract with the local schools. The only thing I get is free admission to the games and a chili supper. Young people deserve to have somebody watching them so they don't get hurt. Most kids will play football for four years, but they'll live to be 75. It's nasty to tear up a leg and have it with you the rest of your life, simply because no one ever watched out for you medically."

"Almost any specialty of physician can be a team physician. All you've got to do is focus a little bit on what constitutes sports injury. I took a sports medicine class several years ago to boost my knowledge. And I read several sports-related medical journals."

Dr. Reid x-rays unfortunate athletes by whisking them directly from the playing field to his office, which contains an antique (1942), but perfectly working x-ray machine (see photo on page 187). "If it's just a bad sprain, I can then tape it immediately. If it's actually broken, then we treat it." Albeit old, the on-site x-ray machine saves lots of driving, since Greenfield is 15 miles from the nearest hospital. ◀

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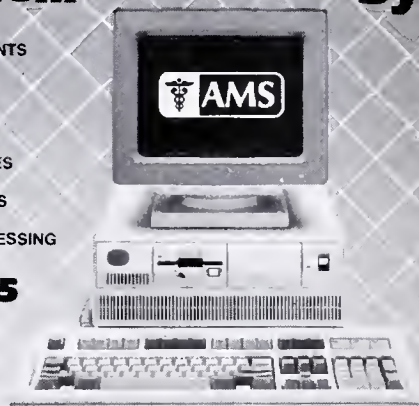
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Nothing Can Replace a Good Friend

One Saturday morning four years ago, Northwestern University Medical School student Joe DiCara took a walk down the street to the Cabrini Green housing project for a game of pick-up basketball. That first one-on-one with a half dozen of the city's poorest children has grown into the Northwestern University Youth Program. Fifty young people from Chicago's ghetto and an equal number of medical and law students meet each week for some reading and writing—and a rare opportunity to learn from one another.

"After four years of college and four years of medical school, most of us get pretty caught up in the business of being adults," Joe DiCara, M.D., said. "Then all of a sudden we're pediatricians and we don't know what it feels like to be a kid anymore."

For six hours every Saturday—and many evenings in between—students and residents know what it feels like. And a group of young people get a glimpse of a life without gang violence and street drugs.

"One of the things that we constantly stress to kids is, 'What do you want to do when you grow up?' And just like any other kid, the children will say, 'I want to be policeman, I want to be a lawyer, I want to be a doctor,' but to those kids they're just words. They don't know how to go from 'I want to be' to 'I'm going to be.' And they rarely have any role models to help them or show them the way. We provide that."

The big sisters and big brothers include doctors who started with the program when they were medical students, law students and people in the community. Those most intimately involved routinely walk through Cabrini Green and visit kids in the projects. They take groups on camping trips and on volunteer excursions to the V.A. Hospital. They get to know parents, many of whom conceived very young and are raising their children alone in a violent, unyielding environment. DiCara sought his residency here, in part, to see some of his charges through high school.

"Our first group of adolescents was a really unique bunch," DiCara said. "We went through some tough times with the kids and never knew how successful we were going to be. But every single one of them graduated from high school and some are in college. And these are tough kids."

The typical Saturday begins with swimming lessons followed by read-



Joe DiCara, M.D.

ing and writing and computer learning games. The morning learning sessions involve fourteen small groups on different subjects for different ages. Lunch (and nutrition lesson) are followed by the one-on-one big brother/big sister time that is the backbone of the role modeling program.

DiCara maintains that the pro-

gram has been a huge boost to his medical education. "To be a pediatrician doesn't only mean understanding the medicine, it means understanding the kid," he said. "And understanding whether the kid will take his medicine, whether his complaints are genuine or secondary to what's going on in the home."

"We have a lot of children in the program I've referred from the hospital. They're asthmatics who haven't been taking their medicines or diabetics who don't take their insulin because their parents tell them to and their doctor, another authority figure, tells them to. Adolescents want to break away. They want to be independent."

"You see kids who are constantly readmitted to the hospital for not taking their medicine or for faking illness or whatever. When they are doing well, they get no positive reinforcement because no one is there to tell them they're doing OK."

"A few minutes with the family physician can have a lot of impact for a young person seeking guidance," DiCara says. "Decisions they

make now are going to influence the rest of their lives. A few minutes of conversation can really go a long way with a kid, especially about how unhealthy lifestyles can wreck your future. Those kinds of topics are easily brought up in a doctor's office."

The direct approach is the only approach, according to DiCara. "If you show a kid that you aren't afraid to talk about something, they aren't going to be afraid either," he said. "Come right out and say, 'You're at an age where a lot of girls are beginning to have sex.'"

"It just never seems to get any easier if you aren't direct about it; you just get more distant from the kid. The child must perceive you as someone they can trust, almost like a friend rather than an authority figure. In the world of medicine or the world in general, sometimes nothing can replace a good friend."

Two years ago, the students did a breakdancing version of "The Wizard of Oz." DiCara said that the year's rehearsals taught some hard lessons about delayed gratification. "They were working on something

every week for a year and it drove them crazy," he said. "We had tons of arguments. Eventually they started realizing how much we cared about them and what we were trying to do."

In "the Wizard of Oz Dancing," Dorothy came not from Kansas but from a Chicago housing project. And the script enabled her to put the program's philosophy into words. Thirteen-year-old Marschan McGraw told the audience of 700 Northwestern students and alumni: "I've learned to have confidence in myself and power to live out my dreams. For I must hold onto my dreams and never let anyone, especially myself, tell me I can't reach them. And then, whether I fully realize those dreams or not, I will not have failed."

Joe DiCara is looking for students and residents from other medical centers who'd be willing to start similar programs for local adolescents. He can be found on any Saturday morning at the Lake Shore Center Dormitory. Fifty young friends with their big brothers and sisters can meet you by the pool at 9:30.

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Agenda

1988 House of Delegates

Robert M. Reardon, M.D., Speaker/Joan E. Cummings, M.D., Vice-Speaker

First Session

9:30 a.m. ——— Friday, April 22, 1988 ——— Westin O'Hare Hotel
Grand Ballroom

- | | |
|---|---|
| 1. Call to order
Robert M. Reardon, Speaker | Presentation of AMA-ERF check to Illinois medical schools |
| 2. Invocation | 11. IMPAC report
George T. Wilkins, Jr., Chairman |
| 3. Report of Credentials Committee | 12. Introduction of AMA Delegates and Alternate Delegates
Robert C. Hamilton, Chairman |
| 4. Report of Committee on Rules and Order of Business | 13. Report of Chairman, Board of Trustees,
Alfred J. Kiessel
Unfinished business A-B |
| 5. Approval of minutes of previous meeting | 14. Remarks of Speaker |
| 6. Memorial service for members deceased since April, 1987, conducted by Harold L. Jensen, Secretary-Treasurer | 15. Resolutions and supplementary reports |
| 7. Introduction of special guests | 16. New business and announcements |
| 8. Remarks of special guests | 17. Recess until 10:00 a.m., Saturday, April 23, 1988 |
| 9. Remarks from ancillary groups
Lynn Kassel, President, Illinois State Medical Society Auxiliary
Cheryl Hutchison, President, Illinois Society of Medical Assistants | Delegates' Buffet—11:30 a.m.-1:30 p.m.
Reference Committees—1:30 p.m.
President's Night—7:00 p.m. |
| 10. Educational Awards
Certificates of appreciation to continuing medical education examiners | |

Second Session

10:00 a.m. ——— Saturday, April 23, 1988 ——— Westin O'Hare Hotel
Grand Ballroom

- | | |
|---|---|
| 1. Call to order by the Speaker | Committee A-Administration |
| 2. Report of Credentials Committee | Committee B-Health Care Economics |
| 3. Introduction of special guests | Committee C-Education & Clinical Service Matters |
| 4. Public Service Awards | Committee D-Governmental Affairs, Public Relations and Miscellaneous Business |
| 5. President's address
Edward J. Fesco | 7. New business and announcements |
| 6. Reports of reference committees
Amendments to Constitution & Bylaws | 8. Recess until 9:00 a.m., Sunday, April 24, 1988 |

Third Session

9:00 a.m. ——— Sunday, April 24, 1988 ——— Westin O'Hare Hotel
Grand Ballroom

- 1. Call to Order by the Speaker
- 2. Report of Credentials Committee
- 3. Induction of Harry A. Springer, President-Elect,
into office of President by Edward J. Fesco
- 4. Address of President Springer
- 5. Announcements and introduction of guests
- 6. Reports of Reference Committees
- 7. Elections

- Report of Nominating Committee
 - a. President-Elect (Downstate)
 - b. 1st Vice-President (Cook County)
 - c. 2nd Vice-President (Downstate)
 - d. Secretary-Treasurer
 - e. Speaker of the House (Downstate)
 - f. Vice-Speaker of the House (Cook County)
 - g. Trustee Terms Expiring

District	Terms expiring
Third District	Ulrich F. Danckers William J. Marshall
Fourth District	Lorris M. Bowers
Seventh District	Alfred J. Kiessel

- h. Delegates to AMA to take office Jan. 1, 1989
and serve until Dec. 31, 1990

Terms expiring

- James H. Andersen, Oak Brook
- Audley F. Connor, Jr., Chicago
- Joan E. Cummings, Hines
- Lawrence L. Hirsch, Northbrook
- Joseph R. O'Donnell, Glen Ellyn
- Pedro A. Poma, Melrose Park
- Richard A. Quinones, Chicago
- P. John Seward, Rockford
- Robert M. Vanecko, Chicago

- Fred Z. White, Chillicothe
- George T. Wilkins, Jr., Edwardsville

Delegate from Downstate to serve immediately
and until December 31, 1989 to complete unex-
pired term.

- i. Alternate delegates to AMA to take office Jan. 1,
1989 and serve until Dec. 31, 1990

Terms expiring

- Juanito S. Bartolome, Jr., Chicago
- Scott Bernstein, Urbana
- H. Constance Bonbrest, Chicago
- Chester C. Danehower, Jr., Peoria
- Manuel O. Guerrero, Moline
- Henrietta Herbolsheimer, Chicago
- Alfred J. Kiessel, Decatur
- Eugene B. Loftin, Elgin
- William J. Marshall, Olympia Fields
- Joseph B. Perez, Rockford

- j. Judicial Panel member to take office April 24,
1988 and serve until April, 1993 (nominated by
ISMS President)

- k. Rules & Order of Business Committee to take
office April, 1988 and serve until April, 1989
(Five (5) delegates nominated by the Speaker
and Vice-Speaker of the House)

- 8. Fixing of per capita dues for 1989
- 9. Selection of meeting place and time for next
meeting
- 10. Unfinished business
- 11. New business
- 12. Adjournment, *Sine Die*

ISMS Delegation to the AMA

Delegation Chairman: Robert C. Hamilton, M.D./Secretary: George T. Wilkins, Jr., M.D.

Delegates

To serve from Jan. 1, 1987 to Dec. 31, 1988

(Elected April 5, 1986)

James H. Andersen, Oak Brook
Audley F. Connor, Jr., Chicago
Joan E. Cummings, Hines*
Lawrence L. Hirsch, Northbrook
Joseph R. O'Donnell, Glen Ellyn
Pedro A. Poma, Melrose Park
Richard A. Quinones, Chicago
P. John Seward, Rockford
Robert M. Vanecko, Chicago
Fred Z. White, Chillicothe
George T. Wilkins, Jr., Edwardsville

To serve from Jan. 1, 1988 to Dec. 31, 1989

(Elected April 12, 1987)

Alfred J. Clementi, Arlington Heights
Jere E. Freidheim, Chicago
Robert C. Hamilton, Chicago
Harold L. Jensen, Flossmoor
Morgan M. Meyer, Lombard
Harry A. Springer, Evanston
Arthur R. Traugott, Urbana
Ronald G. Welch, Belleville
Vacancy

Alternates

To serve from Jan. 1, 1987 to Dec. 31, 1988

(Elected April 5, 1986)

Juanito S. Bartolome, Jr., Chicago
Scott Bernstein, Urbana
H. Constance Bonbrest, Chicago
Chester C. Danehower, Peoria*
Manuel O. Guerrero, Moline
Henrietta Herbolzheimer, Chicago
Alfred J. Kiessel, Decatur
Eugene B. Loftin, Elgin*
William J. Marshall, Chicago
Joseph B. Perez, Rockford

To serve from Jan. 1, 1988 to Dec. 31, 1989

(Elected April 12, 1987)

Randall T. Bellows, Chicago
Albino Bismonte, Gurnee
Ulrich Danckers, River Forest
Earl E. Fredrick, Jr., Chicago
A. Beaumont Johnson, Elgin
Silvana Menendez, Belleville
Robert M. Reardon, Bloomington
Donald K. Rokosch, Danville
Joseph H. Skom, Chicago
M. LeRoy Sprang, Evanston

**Elected April 12, 1987 to serve until Dec. 31, 1988*

Honorary Members

Frank J. Jirka, Jr., Barrington Hills

John J. Ring, Mundelein

Committees of the House of Delegates

Committee on Rules and Order of Business

This committee shall consider all matters regarding rules governing actions, methods and procedure, and the order of business (agenda) for the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker.

Resolutions submitted after the deadline for receiving resolutions (30 days prior to the annual or interim meeting) must be approved by the Committee on Rules and Order of Business, or by a two-thirds vote of the House, before they will be considered as business of the House of Delegates.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

Committee on Credentials

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform other such duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House and one-half hour prior to the opening of the other sessions.

Tellers and Sergeants At Arms

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot is scheduled, or the House goes into executive session.

Reference Committee on Amendments to Constitution and Bylaws

This committee shall consider and report to the House of Delegates its recommendations on all pro-

posed amendments to the Constitution and Bylaws and peer review concerns.

Reference Committee A (Administration)

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to officers, administration, finances, budgets.

Reference Committee B (Health Care Economics)

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to government health programs, including cost containment, health care financing and economics.

Reference Committee C (Education and Clinical Service Matters)

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to education, manpower, clinical medicine, scientific matters and medical services.

Reference Committee D (Governmental Affairs, Public Relations & Miscellaneous)

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to medical-legal matters, governmental affairs, public relations and miscellaneous subjects.

Resolutions

1988 Annual Meeting

ISMS House of Delegates

The following resolutions were received at ISMS headquarters by February 22 and, according to provisions of the bylaws, are printed in *IMJ* by title and subject. Final deadline for resolutions was March 22.

At this writing it is anticipated that other resolutions will have been submitted for consideration before that deadline. These will be included in the Delegates' packet of materials.

Subject		Submitted by
Memorials		
Allan L. Goslin		Edward J. Fesco, President
Lee N. Hamm		Michael C. Snyder, District Five Trustee
Harold A. Sofield		Robert M. Vanecko, Chairman, Cook County Delegation
Unfinished Business Reports		
Report A	Medical Studies Act	Alfred J. Kiessel, for the Board of Trustees
Report B	Anti-Physician Letters	Alfred J. Kiessel, for the Board of Trustees
Resolutions		
1 (A-88)	Medical Malpractice Juries	Edwin S. Sinaiko, Delegate
2 (A-88)	Dues	Harold L. Jensen, for the Board of Trustees
3 (A-88)	ISMS Policy Titled, "Disaster Teams"	Alfred J. Kiessel, for the Board of Trustees
4 (A-88)	ISMS Policy Titled, "Hospital Procedures with Mental & Physical Illness"	Alfred J. Kiessel, for the Board of Trustees
5 (A-88)	ISMS Policy Titled, "Involuntary Certification"	Alfred J. Kiessel, for the Board of Trustees
6 (A-88)	ISMS Policy Titled, "Minimum Standards for Health Insurance Policies"	Alfred J. Kiessel, for the Board of Trustees
7 (A-88)	ISMS Policy Titled, "Workers Compensation"	Alfred J. Kiessel, for the Board of Trustees
8 (A-88)	ISMS Policy on, "Inadequate HMO Psychiatric Benefits"	Alfred J. Kiessel, for the Board of Trustees
9 (A-88)	Physician Manpower and Its Projected Future Excess	Edward S. Warren, for the Vermilion County Medical Society
10 (A-88)	Monitor Malpractice Insurance	Samuel J. Schimel, Delegate
11 (A-88)	Medicare Denials	John J. Taraska, for the Peoria Medical Society
12 (A-88)	"Medically Unnecessary" Letters	Samuel J. Schimel, Delegate
13 (A-88)	Inclusion of Opinion Disclaimers on JAMA Essays	Joseph O'Donnell, for the DuPage County Medical Society

14 (A-88)	Informing Medicare Beneficiaries of Potential Denials	Robert Fitzgerald, for the DuPage County Medical Society
15 (A-88)	Protection of Retirement Assets	Patricia Merwick, for the DuPage County Medical Society
16 (A-88)	Repeal of MAAC Provisions	Joseph O'Donnell, for the DuPage County Medical Society
17 (A-88)	Smoking Ban in Public Buildings and Restaurants	Robert Fitzgerald, for the DuPage County Medical Society
18 (A-88)	Smoking Ban in Hospitals and Public Health Facilities	Erlo Roth, for the DuPage County Medical Society
19 (A-88)	Smoking Ban on Public Transportation	Vedantham Srinivasan, for the DuPage County Medical Society
20 (A-88)	Utilization Parameters for Nursing Home Visits	Joseph O'Donnell, for the DuPage County Medical Society
21 (A-88)	Medical Staff Bylaws for Outpatient Surgi-Centers	Robert M. Vanecko, Chairman, Cook County Delegation

ISMS Annual Meeting

Program Summary By Days

WEDNESDAY, APRIL 20, 1988

2:00 p.m.	ISMIE Executive Committee Meeting
4:00 p.m.	Annual ISMIE Membership Meeting
4:30 p.m.	ISMIE Board of Governors Meeting

THURSDAY, APRIL 21, 1988

9:00 a.m.	ISMS Board of Trustees Meeting
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FRIDAY, APRIL 22, 1988

7:30 a.m.	ISMS Board of Trustees Meeting
7:30 a.m.	Rules and Order of Business Meeting
8:00 a.m.	Registration
8:00 a.m.	Districts 1, 2, 4, 5, 6, 7, 8, 9, 10, 11 & 12 Caucus
8:00 a.m.	CMS Caucus
8:30 a.m.	Meeting of Reference Committee Members
8:30 a.m.	Credentials Committee
9:30 a.m.	House of Delegates
11:15 a.m.	IMPAC Annual Meeting
11:30 a.m.	District Meetings
11:30 a.m.-1:30 p.m.	Delegates' Buffet
1:30 p.m.	Reference Committees
7:00 p.m.	President's Night

SATURDAY, APRIL 23, 1988

7:30 a.m.	Public Affairs Breakfast
8:00 a.m.	Registration
8:30 a.m.	CMS Caucus
8:30 a.m.	Districts 1, 2, 4, 5, 6, 7, 8, 9, 10, 11 & 12 Caucus
9:00 a.m.	Credentials Committee
10:00 a.m.	House of Delegates
10:00 a.m.	Medical Student Section Meeting
Noon	Fifty Year Club Luncheon
1:00 p.m.	ISMIE Network Representative Meeting
1:00 p.m.	CMS Caucus (if necessary)
1:30 p.m.	Credentials Committee
2:00 p.m.	House of Delegates
4:45 p.m.	District 1, 2, 4, 5, 6, 7, 8, 9, 10, 11 & 12 Caucus
6:00 p.m.	IMPAC Sustainer Reception

SUNDAY, APRIL 24, 1988

7:30 a.m.	ISMS Board of Trustees Meeting
8:00 a.m.	Registration
8:30 a.m.	Credentials Committee
9:00 a.m.	House of Delegates
	Board of Trustees Reorganization Meeting immediately following house adjournment.

Notification of IMPAC Annual Meeting

The 1988 Annual Meeting of the Illinois State Medical Society Political Action Committee (IMPAC) will be held on Friday, April 22, 1988, *immediately following the adjournment of the ISMS House of Delegates.*

11:15 a.m. (approximately)

Westin O'Hare Hotel

Rosemont, Illinois

All members are encouraged to attend.

The 1988 IMPAC Nominating Committee has met and nominated the following physicians for membership on the IMPAC Council for terms expiring in 1991:

Edward J. Fesco, LaSalle
Jere E. Freidheim, Chicago
Laurence J. Gott, Barrington Court
Robert C. Hamilton, Chicago
Raymond E. Hoffmann, Rockford
Thomas M. Iannucci, Olympia Fields
Harold L. Jensen, Flossmoor
David B. Littman, Highland Park (to fill a vacancy for a term expiring in 1989)
Tassos P. Nassos, Northbrook
Edward F. Ragsdale, Alton
Alan M. Roman, Flossmoor

YOU'RE INVITED



Breakfast Speaker:
Henry J. Hyde
U.S. Congressman

To a complimentary
Public Affairs Breakfast
Saturday, April 23, 1988,
7:30 a.m.
Westin O'Hare Hotel
Rosemont, Illinois

Tickets for this breakfast will be available at convention registration during the ISMS Annual Meeting on a first come, first served basis.

For further information, please contact the Governmental Affairs Division at ISMS offices, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602. Telephone (312) 782-1654 or (800) 782-ISMS.

ISMS Auxiliary 60th Annual Meeting Westin O'Hare Hotel

WEDNESDAY, APRIL 20

11:30 a.m.	Pin & Gavel Luncheon (Past Presidents Only)
1:00-6:00 p.m.	House of Delegates Registration
2:30-4:30 p.m.	Pre-Convention Board of Directors Meeting
6:30 p.m.	Board of Directors Dinner (Guests & Delegates Welcome)
8:00-10:00 p.m.	Auxiliary Hospitality (Guests & Delegates Welcome)

THURSDAY, APRIL 21

7:30 a.m.	House of Delegates Registration Complimentary Continental Breakfast Reference Committee Personnel Meeting
9:00 a.m.	First House of Delegates Session Call to Order & Greetings Opening Ceremonies Reading of Rules Appointment of Reading & Reference Committees Treasurer's Report Reading of Budget
9:30-9:45 a.m.	President's Report to House
9:45-10:10 a.m.	Keynote Speaker: Mrs. Jean Hill (J. Edward), Secretary of the American Medical Association Auxiliary
10:10-10:40 a.m.	Nominating Committee Report Nominations and Election Instructions
10:40-10:55 a.m.	Launch of "Special Event 1988/89"
10:55 a.m.	Introduction of Resolutions
11:00 a.m.	Reference Committee Hearings Organizational Affairs Health Concerns
Noon	Awards and Recognition Luncheon (Guests and Delegates Welcome) Memorial Service Luncheon Speaker Awards Presentations
1:45-2:15 p.m.	County Presidents-Elect Orientation
2:15 p.m.	House of Delegates Session Continued Elections County Presidents' Reports
3:00 p.m.	Recess
4:00 p.m.	Oak Brook Center Mall Shop & Dine
8:00-10:00 p.m.	International Coffee and Desserts Hospitality (Guests and Delegates Welcome)

FRIDAY, APRIL 22

7:30 a.m.	House of Delegates Registration Reference Committee Reports Available Complimentary Continental Breakfast
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8:45 a.m.	Second House of Delegates Session Reference Committee Reports Budget Approval Election Results
9:00 a.m.	County Reports Continued
9:45 a.m.	Adolescent Health Panel
11:30 a.m.	"Special Event 1988-89"
Noon	President's and Installation Luncheon and International Bridal Show (Guests and Delegates Welcome) Installation of 1987-1988 ISMSA Officers Annual Meeting Adjournment
1:45 p.m.	International Bridal Show
3:00 p.m.	1988-1989 Board of Directors Photograph
3:15 p.m.	Post-Convention Board of Directors Meeting
7:00 p.m.	ISMS President's Night—Honoring Edward J. Fesco, M.D.
	SATURDAY, APRIL 23
7:30 a.m.	ISMS Public Affairs Breakfast

Notice of Annual Meeting of Members of the

Illinois State Medical

Inter-Insurance Exchange

Wednesday, April 20, 1988

4:00 p.m.

Westin O'Hare Hotel, 6100 River Road
Rosemont, Illinois

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BMW 735	\$679	HONDA CIVIC CRX.....	\$127	PONTIAC LeMANS.....	\$128
BUICK LeSABRE.....	\$216	HONDA PRELUDE.....	\$172	PONTIAC GRAND AM.....	\$152
CADILLAC ALLANTE.....	\$752	HYUNDAI EXCEL	\$ 95	PONTIAC GRAND PRIX	\$189
CADILLAC DeVILLE	\$319	ISUZU IMPULSE.....	\$174	PONTIAC BONNEVILLE	\$219
CHEVY BERETTA.....	\$152	ISUZU TROOPER	\$179	PORSCHE 944	\$397
CHEVY BLAZER	\$166	JAGUAR XJ6.....	\$667	PORSCHE 911.....	\$517
CHEVY CORSICA	\$152	LINCOLN TOWN CAR.....	\$339	SAAB 900	\$212
CHEVY CELEBRITY.....	\$167	LINCOLN CONTINENTAL	\$352	SAAB 9000.....	\$324
CHEVY CORVETTE.....	\$389	MAZDA 323.....	\$129	STERLING.....	\$284
CHEVY ASTROVAN	\$172	MAZDA MX6.....	\$162	SUBARU DL	\$154
CHRYSLER LeBARON CONV.....	\$187	MAZDA 929.....	\$257	SUZUKI SAMURAI.....	\$129
CHRYSLER NEW YORKER.....	\$257	MERCEDES 300E	\$549	TOYOTA CELICA.....	\$172
DODGE CARAVAN	\$172	MERCEDES 560SL	\$752	TOYOTA 4 RUNNER.....	\$209
DODGE SHADOW	\$146	MERCURY SABLE.....	\$172	TOYOTA SUPRA	\$287
FORD MUSTANG	\$147	MITSUBISHI MONTERO	\$167	VOLVO DL	\$212
FORD TAURUS.....	\$162	NISSAN STANZA.....	\$162	VOLVO 740	\$287
FORD THUNDERBIRD.....	\$177	NISSAN 4X4	\$179	V.W. JETTA.....	\$152

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Viewbox

(continued from page 140)

Diagnosis: Tuberous sclerosis

The combination of bilateral renal cysts and periventricular calcifications make tuberous sclerosis the most likely diagnosis.

Infantile polycystic disease can be eliminated as a possibility. This disease constitutes a spectrum of abnormalities, including cystic renal disease and hepatic fibrosis. The severity of these two aspects vary inversely. Infants usually die due to renal complications. In later childhood most patients present with portal hypertension due to hepatic fibrosis.¹ Sonography in both infants and older children shows enlarged kidneys which are highly echogenic. No individual cysts are identified due to their small size.²

Adult polycystic disease can be present in a 13-year-old and could present with small cysts prior to enlargement of the kidneys. There is an association with intracranial aneurysms, but not multiple intracranial calcifications.

Medullary cystic disease (juvenile nephronophthisis) is unlikely in this patient. This inherited disease usually presents because of impaired renal function. Sonography sometimes demonstrates a few small medullary or corticomedullary cysts in normal-to-small kidneys. The corticomedullary junction is not well defined.¹ This disease is not associated with intracranial calcifications.

Tuberous sclerosis is an inherited neurocutaneous disorder characterized by hamartomas of many tissues, especially the skin and brain. The classical clinical triad is seizures, mental retardation, and skin lesions. Brain lesions are typically periventricular and are often calcified.

The characteristic renal lesion is the angiomyolipoma. Using computed tomography this benign tumor can be reliably diagnosed due to its characteristic fat content. Angiomyolipomas occur in 40%-80% of patients with tuberous sclerosis.² Multiple renal cysts are less commonly seen in patients with tuberous sclerosis.³ These patients may or may not have identifiable angiomyolipomas. In patients without angiomyolipomas, cystic changes of tuberous sclerosis and cysts of adult polycystic disease cannot be differentiated by imaging methods.

In our patient the history and brain CT findings were most helpful in making the correct diagnosis. While mental retardation is a part of the classic triad of tuberous sclerosis, about 40% of patients have normal intelligence. In some cases, cystic disease of the kidney is the first manifestation of tuberous sclerosis. Tuberous sclerosis should be considered in patients who present with renal cysts. When the diagnosis is in doubt, CT with thin sections has been valuable in identifying small angiomyolipomas.³

This case demonstrates the sensitivity of ultrasound in demonstrating abnormalities of the renal parenchyma.⁴ This high sensitivity, as well as the lack of ionizing

radiation or intravenous contrast material, makes sonography an ideal screening method for children with suspected renal disease, especially cystic disease such as adult polycystic disease.⁵

References

1. Hayden, C.K., et al.: "Renal Cystic Disease in Childhood," *Radiographics* 1:97-116, 1986.
2. Davidson, A.J.: *RADIOLOGY OF THE KIDNEY*. Philadelphia, W.B. Saunders, 1985, pp. 360-364.
3. Mitnick, J.S., et al.: "Cystic Renal Disease in Tuberous Sclerosis," *Radiology* 147:85-87, 1983.
4. Amis, E.S. Jr., Hartman, D.S.: "Renal Ultrasound," *Rad Clin North Amer* 22:315-332, 1984.
5. Walker, F.C. Jr., et al.: "Diagnostic Evaluation of Adult Polycystic Kidney Disease in Childhood," *AJR* 142:1273-1277, 1984.

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May—July, 1988

Specialty Review in Family Medicine
May 1-7, 1988

Specialty Review in Anesthesiology
May 15-20, 1988

Specialty Review in Orthopedic Surgery
May 22-28, 1988

Specialty Review in Pediatric Cardiology
June 1-4, 1988

Microneurosurgery of the Brain
June 2-6, 1988

Flexible Fiberoptic Sigmoidoscopy
June 4, 1988

Spinal Diseases and Stabilization
June 7-9, 1988

Peripheral Nerve Injury and Repair: The Practical Aspects
June 10-12, 1988

Fiberoptic Colonoscopy
July 6-8, 1988

Fiberoptic Esophagogastric Endoscopy
July 11-13, 1988

Specialty Review in Pediatrics
July 18-24, 1988

Specialty Review in Emergency Medicine
July 25-30, 1988

Specialty Review in Internal Medicine
July 31-August 6, 1988



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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it, however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Let's Count Our Blessings And Get to Work



Thank you for the opportunity to serve as your president this year. My message for this first page is very simple. Illinois is a healthy place to live and practice medicine. It's time to count our blessings and get to work.

The Illinois State Medical Society has earned a national reputation among professional societies. We can and do deliver what our members want.

With few exceptions, our elected officials are receptive and sensitive to the health care needs of our citizens. We've worked hard to educate them, and must continue to communicate on the issues.

The 1988 elections are crucial. We must work to replace those elected officials who won't even listen to medicine or show concern for health care issues. And equally important, we must ensure that those who do listen are reelected.

If we succeed, our legislators will be receptive to outstanding tort reform so important to the medical environment. They will understand that caps on noneconomic damages in medical malpractice cases are the most efficient way to ensure that medical care remains available for everyone. They will understand that those huge awards don't happen in a vacuum. Each one impacts those which follow.

More than ever before, physicians must be good communicators.

We must talk to our patients about the issues of the day. We must support our young people and help them to grow. We must be leaders in our communities, because the public health is our day-to-day responsibility.

We'll face many challenges together in the next twelve months. I am confident that the Society can generate the necessary energy and initiative to meet our goals. There is much to be done and we can enjoy doing it well. ◀

A handwritten signature in cursive script that reads "Harry A. Springer".

Harry A. Springer, M.D.
President

IN ANTIHYPERTENSIVE THERAPY **PERFORMANCE**



***Maintains
physical
performance***



***Maintains
mental
performance***



***Maintains
sexual
performance***

COUNTS...

Maintains physical, mental, and sexual performance

- Alpha₁ blockers maintain normal hemodynamics during rest and exercise¹
- Seldom causes depression, confusion, loss of alertness²
- Impotence is rare—incidence equal to placebo³

Significantly decreases total cholesterol*⁴

Effective in younger and older patients, blacks as well as whites¹

Side effects generally were mild and transient. Dizziness and asthenia were most common. Others reported significantly more frequently than with placebo were nasal congestion, peripheral edema, somnolence, nausea, palpitations, and blurred vision. Incidence of syncope (1.0%) was not significantly different from placebo.

* HYTRIN is not indicated for the treatment of hyperlipidemia.

HYTRIN® 1mg,
2mg,
5mg
tablets
(terazosin HCl) **ONCE-A-DAY**
ONE PRICE

The first once-a-day alpha₁ blocker



advancing cardiovascular care

Please see adjacent page for Brief Summary of prescribing information.

HYTRIN®

(terazosin hydrochloride tablets)

Brief Summary

CLINICAL PHARMACOLOGY: Pharmacodynamics: Clinical studies of terazosin used in once-a-day (majority) and b.i.d. regimens with total doses usually in the range of 5-20mg/day, in patients with mild or moderate hypertension. Because terazosin, like all alpha antagonists, can cause large falls in blood pressure after the first dose or first few doses, the initial dose was 1mg in virtually all studies, with subsequent titration to a specified fixed dose or titration to a specified blood pressure endpoint.

Blood pressure responses were measured at the end of the dosing interval (usually 24 hrs.) and effects were shown to persist throughout the interval, with usual supine responses 5-10mmHg systolic and 3-5mmHg diastolic greater than placebo. The responses in the standing position tended to be somewhat larger, although this was not true in all studies. The magnitude of blood pressure responses was similar to prazosin and less than hydrochlorothiazide (in a single study). In measurements 24 hrs. after dosing, heart rate was unchanged.

Limited measurements of peak response (2-3 hrs. after dosing) during chronic terazosin administration indicate that it is more than twice the trough (24 hr.) response, suggesting some attenuation of response at 24 hrs., presumably due to a fall in blood terazosin concentrations at the end of the dose interval. This explanation is not established with certainty and is not consistent with the similarity of blood pressure response to once-a-day and b.i.d. dosing. With the absence of an observed dose-response relationship over a range of 5-20mg, i.e., if blood concentrations fall to the point of providing less than full effect at 24 hrs., a shorter dosing interval or larger dose should lead to increased response. Measure blood pressure (BP) at the end of the dose interval, if response is not satisfactory, patients may be tried on a larger dose or b.i.d. regimen. The latter should be considered if side effects, such as dizziness, palpitations, or orthostatic complaints, are seen within a few hours after dosing.

The greater BP effect associated with peak plasma concentrations (first few hours after dosing) appears somewhat more position-dependent (greater in the erect position) than the effect of terazosin at 24 hrs. In the erect position there is a 6-10 bpm increase in heart rate in the first few hours after dosing. During the first 3 hrs. after dosing 12-5% of patients had a systolic pressure fall of 30mmHg or more from supine to standing, or standing systolic pressure below 90mmHg with a fall of at least 20mmHg, compared to 4% of a placebo group.

INDICATIONS AND USAGE: Indicated for the treatment of hypertension.

CONTRAINDICATIONS: None known.

WARNINGS: Syncope and "First-dose" Effect: Terazosin, like other alpha-adrenergic blocking agents, can cause marked hypotension, especially postural hypotension, and syncope in association with the first dose or first few doses. A similar effect may occur if therapy is interrupted for more than a few doses. Syncope has been reported with other alpha-adrenergic blocking agents in association with rapid dosage increases or introduction of another antihypertensive drug. Syncope may be due to an excessive postural hypotensive effect, although occasionally the syncopal episode has been preceded by severe supraventricular tachycardia with heart rates of 120-160 bpm.

To decrease the likelihood of syncope or excessive hypotension, always initiate treatment with a 1mg dose at bedtime. The 2mg and 5mg tablets are not indicated as initial therapy. Increase dosage slowly, and add additional antihypertensive agents with caution. Caution patients to avoid situations where injury could result if syncope occurs during initiation of therapy.

In early studies, where increasing single doses up to 7.5mg were given at 3 day intervals, tolerance to the first dose phenomenon did not necessarily develop and the "first dose" effect was observed at all doses. Syncopal episodes occurred in 3 of 14 subjects given doses of 2.5, 5, and 7.5mg, which are higher than the recommended initial dose. Severe orthostatic hypotension (BP 50/0mmHg) was seen in two others and dizziness, tachycardia, and lightheadedness occurred in most subjects. These adverse effects all occurred within 90 min. of dosing.

In multiple dose clinical trials involving nearly 2000 patients, syncope was reported in about 1% of patients, in no case severe or prolonged, and was not necessarily associated with early doses.

If syncope occurs, place patient in recumbent position and treat supportively. There is evidence that the orthostatic effect of terazosin is greater, even in chronic use, shortly after dosing.

PRECAUTIONS: General. *Orthostatic Hypotension:* While syncope is the most severe orthostatic effect of terazosin, other symptoms of lowered BP, such as dizziness, lightheadedness and palpitations, are more common, occurring in 28% of patients in clinical trials. Patients with occupations in which such events represent potential problems should be treated with particular caution.

Information for Patients: Make aware of possibility of syncopal and orthostatic symptoms, especially at initiation of therapy, and to avoid driving or hazardous tasks for 12 hrs. after the first dose, after a dosage increase, and after interruption of therapy when treatment is resumed. Caution to avoid situations where injury could result should syncope occur during initial therapy. Advise to sit or lie down when symptoms of lowered BP occur and to rise carefully from a sitting or lying position. Bothersome dizziness, lightheadedness, or palpitations should be reported to physician.

Tell patients that drowsiness or somnolence can occur, requiring caution in people who must drive or operate heavy machinery.

Laboratory Tests: Small but statistically significant decreases in hematocrit, hemoglobin, WBC, total protein and albumin were observed in clinical trials. The magnitude of decreases did not worsen with time. These findings suggest the possibility of hemodilution.

Drug Interactions: In controlled trials, terazosin was added to diuretics, and several beta-adrenergic blockers, no unexpected interactions were observed. Terazosin has also been used concomitantly without interaction in at least 50 patients on the following: 1) analgesic/anti-inflammatory (acetaminophen, aspirin, codeine, ibuprofen, indomethacin), 2) antibiotics (erythromycin, trimethoprim and sulfamethoxazole), 3) anticholinergic/sympathomimetics (phenylephrine HCl, phenylpropanolamine HCl, pseudoephedrine HCl), 4) antitumor (allopurinol), 5) antihistamines (chlorpheniramine), 6) cardiovascular agents (atenolol, hydrochlorothiazide, methyclothiazide, prazosin), 7) corticosteroids, 8) gastrointestinal agents (lactulose), 9) hypoglycemics, 10) sedatives and tranquilizers (diazepam).

Carcinogenesis, Mutagenesis, Impairment of Fertility: HYTRIN was devoid of mutagenic potential when evaluated *in vivo* and *in vitro*.

HYTRIN, administered in feed to rats at doses of 8, 40, and 250mg/kg/day for 2 yrs., was associated with a statistically significant increase in benign adrenal medullary tumors of male rats exposed to the 250mg/kg dose. This dose is 695 X max. recommended human dose (20mg/55kg). Female rats were unaffected. HYTRIN was not oncogenic in mice when administered in feed for 2 yrs. at a maximum tolerated dose of 32mg/kg/day.

The absence of mutagenicity in a battery of tests, of tumorigenicity of any cell type in the mouse carcinogenicity assay, of increased total tumor incidence in either species, and of proliferative adrenal lesions in female rats, suggests a male rat species-specific event. Numerous other diverse pharmaceutical and chemical compounds have been associated with these tumors in male rats without supporting evidence for carcinogenicity in man.

Effects on fertility were assessed in a standard fertility/reproductive performance study in which male and female rats were administered oral doses of 8, 30 and 120mg/kg/day. Four of 20 male rats given 30mg/kg and 5 of 19 male rats given 120mg/kg failed to sire a litter. Testicular weights and morphology were unaffected. Vaginal smears at 30 and 120mg/kg/day appeared to contain less sperm than smears from control matings and good correlation was reported between sperm count and subsequent pregnancy.

Oral use for 1 or 2 yrs. elicited a statistically significant increase in testicular atrophy in rats exposed to 40 and 250mg/kg/day, but not in rats exposed to 8mg/kg/day (> 20 X max. recommended human dose). Testicular atrophy was observed in dogs dosed with 300mg/kg/day (> 800 X max. recommended human dose) for 3 months but not after 1 yr. when dosed with 20mg/kg/day. This lesion has also been seen with Minipress®.

Pregnancy: Teratogenic effects: Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women and the safety of terazosin in pregnancy has not been established. HYTRIN is not recommended during pregnancy unless potential benefit justifies potential risk to mother and fetus.

Nonteratogenic effects: In a peri- and post-natal development study in rats, significantly more pups died in the group dosed with 120mg/kg/day (> 300 X max. recommended human dose) than in the control group during the 3-week post-partum period.

Nursing Mothers: It is not known whether terazosin is excreted in breast milk, therefore, exercise caution when administering terazosin to a nursing woman.

Pediatric Use: Safety and effectiveness have not been determined.

ADVERSE REACTIONS: The prevalence of adverse reactions has been ascertained from 14 placebo-controlled studies conducted primarily in the U.S. The studies involved once-a-day administration of terazosin as monotherapy or in combination with other antihypertensive agents, at doses ranging from 1 to 40mg. All adverse events reported during these studies were recorded as adverse reactions. Adverse events where the prevalence rate in the terazosin group was at least 5%, where the prevalence rate for the terazosin group was at least 2% and was greater than the prevalence rate for the placebo group, or where the reaction is of particular interest are summarized below. Only asthenia, blurred vision, dizziness, nasal congestion, nausea, peripheral edema, palpitations and somnolence were significantly ($p < 0.05$) more common in patients receiving terazosin than in patients receiving placebo. Other events include: [TERAZOSIN-%PLACEBO]: asthenia (11.3% 4.3%), back pain (2.4% 1.2%), blurred vision (1.6% 0.3%), depression (0.3% 0.2%), dizziness (19.3% 7.5%), dyspnea (3.1% 2.4%), edema (0.9% 0.6%), headache (16.2% 15.8%), impotence (1.2% 1.4%), incontinence (0.6% 0.2%), nasal congestion (5.9% 3.4%), nausea (4.4% 1.4%), nervousness (2.3% 1.8%), pain extremities (2.6% 3%), palpitations (4.3% 1.2%), paresthesia (2.9% 1.4%), peripheral edema (5.5% 2.4%), postural hypotension (1.3% 0.4%), sinusitis (2.6% 1.4%), somnolence (5.4% 2.6%), tachycardia (1.9% 1.2%), weight gain (0.5% 0.2%).

Adverse reactions were usually mild or moderate in intensity but sometimes were serious enough to interrupt treatment. Adverse reactions that were most bothersome as judged by being reported as reasons for discontinuation of therapy by at least 0.5% of the terazosin group and being reported more often than in the placebo group [TERAZOSIN-%PLACEBO] are: asthenia (1.6% 0%), blurred vision (0.6% 0%), dizziness (3.1% 0.4%), dyspnea (0.9% 0.6%), headache (16.2% 15.8%), incontinence (0.6% 0.2%), nasal congestion (5.9% 3.4%), palpitations (4.3% 1.2%), paresthesia (2.9% 1.4%), peripheral edema (5.5% 2.4%), postural hypotension (1.3% 0.4%), somnolence (5.4% 2.6%), syncope (0.5% 0.2%), tachycardia (0.6% 0%).

Additional adverse reactions have been reported, but these are not distinguishable from symptoms that might have occurred in the absence of exposure to terazosin. The following additional adverse reactions were reported by at least 1% of 1987 patients who received terazosin in clinical studies or during marketing experience: abdominal pain, abnormal vision, anxiety, arrhythmia, arthralgia, arthritis, bronchitis, chest pain, cold symptoms, conjunctivitis, constipation, diarrhea, dry mouth, dyspepsia, epistaxis, facial edema, fever, flatulence, flu symptoms, gout, increased cough, insomnia, joint disorder, myalgia, neck pain, pharyngitis, pruritus, rash, rhinitis, shoulder pain, sweating, tinnitus, urinary frequency, urinary tract infection, vasodilation, vomiting.

DOSEAGE AND ADMINISTRATION: Dose and dose interval (12 or 24 hrs.) should be adjusted according to BP response.

Initial Dose: 1mg at bedtime. Observe the initial dosing regimen strictly to minimize potential for severe hypotensive effects.

Subsequent Doses: Slowly increase dose to achieve desired BP response. Usual dose range is 1mg to 5mg once a day. Some patients may benefit from doses up to 20mg/day. Doses over 20mg do not appear to provide further BP effect. Doses over 40mg have not been studied. Monitor BP at the end of dosing interval to assure control is maintained. It may be helpful to measure BP 2-3 hrs. after dosing to see if maximum and minimum responses are similar, and to evaluate symptoms which can result from excessive hypotensive response. If response is substantially diminished at 24 hrs. consider an increased dose or b.i.d. regimen. If administration is discontinued for several days or longer, reinstitute therapy using initial dosing regimen. In clinical trials, except for the initial dose, the dose was given in the morning.

Use With Other Drugs: Caution should be observed when terazosin is administered concomitantly with other antihypertensive agents (e.g., calcium antagonists) to avoid the possibility of significant hypotension. When adding a diuretic or other antihypertensive agent, dosage reduction and retitration may be necessary.

August, 1987 Abbott Health Care Products, Inc. North Chicago, IL 60064

8023854

References: 1. Dzau VJ: Evolution of the clinical management of hypertension; Emerging role of "specific" vasodilators as initial therapy. *Am J Med* 1987;82(suppl 1A):36-43. 2. Data on file, Abbott Pharmaceuticals. 3. Mersey JH: Alpha-blockade in hypertension management. *Prim Cardiol* 1987;13:93-101. 4. Hytrin: Product Information Abbott Pharmaceuticals.

Here's Your Chance to Help Us Help You

What ISMS Knows:

Continuing medical education (CME) is important for physicians and patients.

What ISMS Needs to Know:

What topics are most important to the Illinois physician.

How and where the Illinois physician prefers to obtain CME.

How can ISMS best serve its members in providing CME.

Tell us what we need to know about your needs.

Watch for the ISMS Committee on CME Activities Needs Assessment Survey to arrive in the mail in late April. Take a few moments to complete and return it.

You can help ISMS remain responsive to its members' needs and continue spending your dues dollars wisely.

Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

Contraindications: There are no known contraindications to the use of 'Tagamet'.

Precautions: While a weak antiandrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chloridiazepoxide, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.),

demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states [e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation], predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly un-

likely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only), and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

Liquid: 300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).

Injection: Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage® Vials: 300 mg./2 ml. in single-dose, ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl (brand of cimetidine hydrochloride) injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

* ADD-Vantage® is a trademark of Abbott Laboratories.

BRS-TG-L73B

Date of Issuance Apr. 1987

SK&F LAB CO.

Cidra, P.R. 00639

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in peptic ulcer:

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REASSURANCE
REWARD



Tagamet®
brand of **cimetidine**
First to Heal

You'll both feel good about it.

RESULTS

ABSTRACTS OF ACTIONS

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and

are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

January 30, 1988

ISMS Conference Complex

COMMUNICATIONS

The Board heard a presentation on Phase II of the ISMS Communications Study. The presentation included a review of the results of Phase I, which was an opinion study of ISMS communications. Phase II calls for the creation of a tabloid newspaper, called *Illinois Medicine*, to be inaugurated in January 1989. The presentation described the mechanics of implementation and the development of internal editorial decision procedures. Budget information was included both for initial development stages in 1988, and the first year of publication in 1989. The Board accepted Phase II and authorized implementation of its recommendations.

MEDICARE PART B

The Board reviewed a report regarding letters received by Illinois physicians and their patients from the Medicare Part B carrier with an Explanation of Medicare Benefits (EOMB) stating that there has been a denial of payment for a medically-unnecessary procedure. The Board agreed to: (1) Contact appropriate members of the Illinois Congressional Delegation identifying the extent of this problem and the unfairness of the process; (2) Inform the AMA of this and encourage them to intercede with HCFA to effect a change in the mechanisms for denial notification by the carrier; and (3) Distribute information to the ISMS membership indicating the status of this issue and suggestions as to how physicians may overcome these problems with their individual patients.

MEDICAL LICENSURE

The Board appointed an Ad Hoc Committee to determine if action was needed to change licensure rules to allow the Medical Licensure Committee discretionary authority to accept foreign residency training. The Ad Hoc Committee was further directed to review the manner in which pre-1985 medical school graduates are licensed under the Medical Practice Act of 1987. Under the new Medical Practice Act, persons applying for licensure in Illinois must have completed two years of post-graduate training. Those persons applying for a residency in Illinois who graduated from medical school prior to January 1, 1985, cannot receive a temporary license for their residency. In addition, those persons who graduated prior to 1985 and who

failed to perfect licensure in another jurisdiction cannot receive a permanent license.

BUDGET FOR 1988

The Board reviewed the 1988 budget proposal which reflected minimal program changes. Part of this consideration was the necessity of a dues increase. During the past six years, dues have increased \$70.00, to a current level of \$273. As established ongoing programs continue, additional revenue is required, since expenses increase. No dues increase was effected for 1988, even though there was a budgeted deficit of \$654,000. Projections over the next four years have been developed in order to identify a balanced budget, which would also maintain the required level of undesignated surplus. Without an increase in revenue, there will be a continuously-increasing deficit. The 1988 budget reflected increased expenses of 8.4% with a revenue increase of 10.4%. Based upon this review, the Board approved a 1988 budget reflecting \$4,382,514 in revenue and \$4,981,812 for expenses. Recognizing this deficit and projected future deficits, the Board also approved submitting a resolution to the House of Delegates recommending a \$78.00 per year dues increase starting in 1989 with no further increases to be considered until 1991.

POSITIONS ON HIV ANTIBODY TESTING

The Board adopted the following position statements on HIV antibody testing:

■ HIV Antibody Testing for Marriage License Applicants

ISMS recognizes that HIV antibody testing of applicants for marriage licenses may have a limited value as a means of preventing and controlling HIV infection. However, physicians must, by law, counsel marriage license applicants, especially those who participate in high-risk behavior, regarding AIDS, ARC and the transmission of HIV.

ISMS supports the distribution of informational material on AIDS, ARC and HIV infection to physicians and to couples applying for a marriage license and encourages the Illinois Department of Public Health to make such materials available.

Continued on page 282



Penetration plus Duration*

Superior tissue penetration and duration of action

DURICEF[®]

(CEFADROXIL)

... the oral cephalosporin with
once- or twice-a-day dosing

*May not correlate with clinical results.

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For Brief Summary, please see following page.

DURICEF® (CEFADROXIL)

Penetration plus Duration
in Oral Cephalosporin Therapy

INDICATIONS: DURICEF (cefadroxil) is indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms: Urinary tract infections caused by *E. coli*, *P. mirabilis*, and *Klebsiella* species. Skin and skin structure infections caused by staphylococci and/or streptococci. Pharyngitis and tonsillitis caused by Group A beta-hemolytic streptococci. (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. DURICEF is generally effective in the eradication of streptococci from the nasopharynx, however, substantial data establishing the efficacy of DURICEF in the subsequent prevention of rheumatic fever are not available at present.)

Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

CONTRAINDICATIONS: DURICEF is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

WARNING: IN PENICILLIN-ALLERGIC PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF PENICILLINS AND CEPHALOSPORINS, AND THERE ARE INSTANCES OF PATIENTS WHO HAVE HAD REACTIONS TO BOTH DRUGS (INCLUDING FATAL ANAPHYLAXIS AFTER PARENTERAL USE).

Any patient who has demonstrated a history of some form of allergy, particularly to drugs, should receive antibiotics cautiously and then only when absolutely necessary. No exception should be made with regard to DURICEF (cefadroxil). **Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use.** Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Moderate to severe cases should be managed with fluid, electrolyte and protein supplementation as indicated. When the colitis is not relieved by drug discontinuance or when it is severe, oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should also be considered.

PRECAUTIONS: Patients should be followed carefully so that any side-effects or unusual manifestations of drug idiosyncrasy may be detected. If a hypersensitivity reaction occurs, the drug should be discontinued and the patient treated with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

DURICEF (cefadroxil) should be used with caution in the presence of markedly impaired renal function (creatinine clearance rate of less than 50 ml/min/1.73M²). (See Dosage and Administration section of Prescribing Information.) In patients with known or suspected renal impairment, careful clinical observation and appropriate laboratory studies should be made prior to and during therapy.

Prolonged use of DURICEF may result in the overgrowth of non-susceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug. DURICEF should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to 11 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cefadroxil. There are, however, no adequate and well controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Caution should be exercised when cefadroxil is administered to a nursing mother.

ADVERSE REACTIONS: Gastrointestinal—Symptoms of pseudomembranous colitis can appear during antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity—Allergies (in the form of rash, urticaria, and angioedema) have been observed. These reactions usually subsided upon discontinuation of the drug.

Other reactions have included genital pruritus, genital moniliasis, vaginitis, and moderate transient neutropenia.

Before prescribing or administering, see package insert

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PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

ALTON:

Population in St. Louis metro area is over 2 million. Located 25 miles from downtown St. Louis. Four community hospitals available for staff privileges. Opportunities for internal medicine, cardiology, neurology, gastroenterology, pediatrics, oncology, and anesthesiology. Fully equipped offices available. Scheduled hours, free rent, staff salary support, marketing assistance, partnership shares are available and attractive income support arrangements. Contact Jan C. Vest, Administrator, Doctors Clinic, Alton, Illinois (618) 474-8000 or 800-325-3571. (6)

CRYSTAL LAKE:

Population 20,000. Three board certified family practitioners, losing an associate July, 1988. Service area—35,000. Community offers fine opportunity for fulfilling medical practitioner, numerous cultural, recreational facilities, good family life. Contact: John Wall, 280 Virginia, Crystal Lake, 60014 (815) 459-2678 (6)

FREEPORT:

Four busy board certified FPs seeking board certified FP. Pleasant town of 30,000. 100 miles from Chicago. Contact: Family Medical Associates, 1815 W Church St., Freeport 61032; (815) 235-3165. (1)

MACOMB:

Chief of staff. Western Illinois University is accepting applications for medical chief of staff at its Health Center. This is a 12 month position in a multi-faceted outpatient clinic serving 11,000 students. Starting date July 1, 1988. Salary competitive and commensurate with experience. Excellent fringe benefits, malpractice paid. A letter of application along with a curriculum vitae and three references should be forwarded to: Mr. Earl Bracey, Chairman, Search Committee for Medical Chief of Staff, 315 Sherman Hall, W.I.U., Macomb, IL 61455. Ethnic minorities, women and handicapped persons are encouraged to apply. (6)

ROBINSON:

OB/GYN: BC/BE needed in family oriented community with a drawing area of 25,000. Progressive JCAH approved 107 bed hospital. Excellent medical staff. Highly competitive compensation package including income, office space, personnel, etc. Excellent opportunity for GYN Surgery. Hospital located in Southern Illinois near large referral centers, shopping centers. Contact: M. Jean Chambless, Administrator, Crawford Memorial Hospital, Robinson, Illinois 62454 (6)



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Strengthening the Student Section

BY RODERICK L. MATTICKS, DELEGATE, SIU SCHOOL OF MEDICINE
AND DONNA M. WEBER, SECRETARY, ISMS-MSS GOVERNING
COUNCIL

Recently we officially established a medical student section at Southern Illinois University School of Medicine in Springfield. This idea was born out of discussions last spring which were aimed at strengthening our local, state, and national activities. We felt that the problems we were experiencing in organization and adequate representation were multifaceted. Geography represented one major obstacle. Our downstate location has hindered our contribution to the state level. The split location of the campuses—Carbondale for the first year, and Springfield for the past three—has been a significant obstacle to recruitment, participation, representation, and continuity of membership services. Having only one delegate and alternate delegate to represent and coordinate activities which virtually spanned the entire state was another major obstacle. Fortunately we have had at least two more students representing our needs by serving as members on various ISMS councils and committees. We feel we have embarked on an adventure which will greatly improve our membership, representation, and contribution to the local, state, and national organizations.

Here at SIU we have been fortunate to be allowed student representation on the Board of Directors of the Sangamon County Medical Society. In the past two years we have had the opportunity to fill those posts. The concept of establishing the Sangamon County Medical Society Medical Student Section (SCMS-MSS) was presented to the Board of Directors at the September, 1987 meeting. The goals were to achieve a concerted organization of student members, to provide an avenue for better representation of student needs and concerns, to better maintain recruitment and assure continuity of membership services and benefits, and to increase student interest, awareness, and participation in the activities of the county, state, and national organizations. The concept was met with generous support and approval. By November the Constitution of the SCMS-MSS was presented to the Board of Directors. In December, it received approval and the MSS was allowed to set sail. The concept of the SCMS-MSS met with overwhelming approval of the student body as well. Many have expressed interest and support.

The SCMS-MSS Governing Council is made up of two elected

representatives from each class, and the state-elected delegate and alternate delegate. Committee representatives and invited individuals also attend meetings. The Governing Council chairman, vice-chair, and secretary are elected from within the class representatives. Our first Governing Council meeting was held February 5th. The Constitution was ratified, goals were delineated, and resolutions for the upcoming ISMS and AMA meetings were discussed. Business of the SCMS-MSS is similar to the state and national MSS councils and assemblies.

We are excited about the establishment of the SCMS-MSS. The support from the student members and the SCMS has been outstanding. We would like to encourage other medical students to pursue similar activities.

The AMA-MSS Technology Manual is an excellent source for information. We would be happy to provide more information or meet with anyone interested and may be contacted either through the ISMS Chicago office or through Sangamon County Medical Society, 611 N. Sixth, Springfield, Illinois, 62702. ◀

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Spare your patients the rigors of
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Before prescribing, see complete
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The following is a brief summary.

WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or

without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin (ACTH)). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The

following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth, anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ-L45

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THE INFORMED PHYSICIAN

THE INFORMED PHYSICIAN KNOWS WHAT QUESTIONS TO ASK, WHAT ISSUES TO RESOLVE AND WHEN TO CONSULT AN ATTORNEY, ACCOUNTANT OR ACTUARY WHEN CONSIDERING CONTRACTING WITH ALTERNATIVE DELIVERY SYSTEMS. THE ISMS OFFICE OF CONTRACTUAL SERVICES PRESENTS "THE INFORMED PHYSICIAN" AS AN EDUCATIONAL TOOL DESIGNED TO ILLUSTRATE, THROUGH REAL-LIFE SITUATIONS, THE SIGNIFICANT LEGAL AND ECONOMIC ISSUES WHICH FREQUENTLY ACCOMPANY CONTRACTS FOR THE DELIVERY OF HEALTH CARE, AND TO ALERT PHYSICIANS OF WAYS IN WHICH CONTRACTS MAY AFFECT THE PRACTICE OF MEDICINE.

The Obvious, the Obscure, the Hidden **Three Risks**

BY JUDEE GALLAGHER, J.D./CHICAGO

The morning mail brings a memorable letter from the ABC HMO. According to the HMO, you "have difficulty fulfilling the role of medical manager" and will receive only 50% of your capitation payments; the other half will be withheld. Quite a reduction from the 80% you had been receiving. Several questions race through your mind. What went wrong? What specific "difficulty" are they referring to? Can they really do this? How can I provide the physician covered services with only half of my HMO income at my disposal? There must be some mistake.

But there isn't. Some HMOs place primary care physicians at risk for financial penalties beyond the percentage of payment withheld as stated in the contract. The mechanism used in this scenario, and appearing in HMO and IPA contracts with greater frequency, is to increase the percentage of payment withheld based on the utilization performance of the individual physician.

An examination of the kind of contract which placed the physician in this predicament may be helpful. Three areas of financial risk exist in our example contract. One is clearly discernible; one is obscure; the third is hidden. In reading the contract you could easily overlook it.

A common and clearly visible financial risk often looks like this:

Physician accepts sole financial responsibility for the provision of services listed in Exhibit A and Physician agrees to accept the capitation payments, as stated in Exhibit B, as full payment for such services.

The capitation payment is computed by multiplying the number of members assigned to you (with no minimum number guaranteed) by the capitation rate set by the HMO. You receive a fixed amount each month for each member, regardless of the care received by the member. In other words, the actual physician services utilized by a member does not increase or decrease the capita-

tion rate. Generally speaking, all capitation systems contain this clearly visible risk. In a nutshell: will the capitation payments you receive be sufficient to pay for the services you are financially liable for providing?

Of course, even obvious risks can be minimized. Does the contract *specifically* list the services you are financially responsible for providing? Does the contract prohibit the HMO from adding services without a corresponding increase in the capitation rate? If not, what some may call a "manageable risk" others might characterize as "a shot in the dark". (See *The Informed Physician*, "What Are Your Odds; Evaluating Capitation Payments," *IMJ*, Oct. and Nov. 1987).

A second risk commonly encountered is the withholding of a portion (in our example 20%) of the capitation payment owed you. The withheld amount is placed in a risk-sharing pool. It's no surprise under this arrangement that you will only have 80% of the capitation at your

HMO
PPO
IPA

Before
you
sign,
negotiate

Before
you
negotiate,
review



CONTRACT REVIEWS

The ISMS Office of Contractual Services reviews HMO, PPO and IPA contracts for members. The cost is \$100 per review.

Reviews do not constitute legal advice. They provide a working document which highlights key issues, such as malpractice coverage, reimbursement concerns and practice limitations.

For further information contact:

ISMS Office of Contractual Services
Twenty North Michigan Ave., Suite #700
Chicago, Illinois 60602

(2) 782-1654 or (800) 782-ISMS

disposal to pay for 100% of the primary care physician covered services. Whether you receive the 20% back at the year-end is dependent, in our example, on the extent that members assigned to you utilize referral and institutional providers. The HMO allocates an amount that it believes is sufficient to cover referral and inpatient services for each member assigned to you. The amount is frequently called your "target" utilization allocation. The actual referral and inpatient services used by your patient are charged against the target allocation on an ongoing basis. If the HMO determines at year-end that your actual costs for referral and institutional care exceed the target, there is a deficit. In our contract a deficit of \$1.00 or \$10,000 in your target allocation causes the automatic loss of your entire 20% withheld. This is the case, even if the aggregate target allocation (the total allocation for the utilization of referral and inpatient services by all primary care physicians in your network) shows a surplus.

Although the 20% withhold, *relatively* speaking, is stated in understandable language, the risk sharing provisions may be "obscure" or misleading. The scope of the risk sharing itself may be an illusion. For example: If the aggregate utilization experience creates a surplus and an individual physician's deficit is less than the 20% withheld, why is the physician excluded *both* from receiving a portion of the withheld back *and* sharing in the surplus?

Let's return to your morning mail. Why can the HMO increase your withhold to 50%? When you signed the contract you accepted a "hidden" risk which may look like this:

Physician and HMO agree that HMO may increase the percentage of the Physician's withhold amount as the financial needs of the HMO dictate.

Maybe you passed right over this sentence without a second thought. After all, isn't it in your best interests if the HMO is financially successful? Maybe you thought that the increase would apply across the board equally to all the physicians in the network and would be minimal. Perhaps you reasoned that the increase would only be used as a last resort to keep the HMO afloat after an unexpected crises. But since none of these qualifications were written into the contract, you arguably gave the HMO "carte blanche." The HMO determines what "financial needs" may trigger the increase in the withhold amount. Further, the contract contains no restriction on the amount of the increase or how it is applied.

In our example, the HMO increased the withhold to 50% because the primary care physician's costs for referral and hospitalization exceeded the HMO's target. Perhaps recurrent heart attacks, hospitalization to give birth, and an appendicitis accounted for the inpatient care utilized. Assume the HMO agreed that all care rendered was "medically necessary" and the physician adhered to the utilization review procedures, but the physician's cost for referral and hospitalization still exceeded the target. What is the purpose of the risk sharing pool if not to absorb this deficit?

An increase in the percentage of capitation withheld is one way HMOs penalize physicians for deficits beyond the withhold amount. There are other ways. Because

you're an informed physician who recognizes the complex issues involved in contracts for the delivery of medical care, your first step is to send the contract offered you or your IPA to the ISMS Office of Contractual Services. As a *members only service*, the office provides objective comments on any HMO, PPO or IPA contract for the nominal fee of \$100. Contract reviews highlight "standard of care," compensation and insurance issues, and pinpoint ambiguous language and inconsistent or contradictory provisions.

The review is a basic tool to help understand the contract. It's a good first step, but never a substitute for a careful reading of the contract itself. It's not legal advice and the office cannot recommend that any contract is good or bad and should or shouldn't be signed. Each physician (or physician's corporation or partnership) must make that decision. The informed physician's personal attorney and accountant must be consulted before decisions are made.

Your attorney has undoubtedly explained that when you are considering an Individual Participation Agreement with an HMO, PPO or IPA you may not band together with other physicians to negotiate the contract collectively, because that violates antitrust laws. You can, however, individually negotiate your own contract by yourself or with your personal attorney or financial advisor.

Judee Gallagher, J.D., is a Chicago private practice attorney retained by the ISMS Office of Contractual Services since 1985.



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Today, most commercial professional liability insurers have abandoned the Illinois market. But there's still one company writing malpractice coverage up to \$2 million per incident with a \$4 million aggregate—the Illinois State Medical Inter-Insurance Exchange.

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In the continually changing liability climate, the Exchange's directors will continue to make the sound business decisions necessary to ensure the company's long-term financial stability. But as physicians themselves, they also will be making those decisions from a policyholder's perspective. And that will translate into the best possible insurance coverage available, including...

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As a company owned and operated by physicians, the Exchange exists solely for the benefit of its policyholders. Some 9,000 physicians in Illinois are depending upon us. And we don't intend to let them down.

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Time to Change the System

By BRUCE DOBLIN, M.D., NORTHWESTERN UNIVERSITY

Never before in the history of medicine has there been so much time and energy spent reevaluating medical residencies as in the last two years. Much can be learned about the medical establishment in reviewing the way in which this debate reached its current level of discussion and how it is being resolved.

For those who have missed this brouhaha, it began with the death of Libby Zion, who entered New York Hospital in March of 1984 with fever and delirium. She died within twelve hours of her admission. While the cause of her death is still uncertain, the ramifications of this malpractice case will be far-reaching for the way in which they will most likely reshape the current structure of postgraduate medical training across the nation. The grand jury decision, in favor of Ms. Zion's parents, attributed her death to the lack of adequate supervision from attending physicians and the long and arduous working hours of interns and residents.

So, where did this uproar over resident work hours come from? Did it come from New York Hospital or the local medical school? Did it come from the residents at New York Hospital or the attending phy-

sicians? No, it came from a segment of the television show "Sixty Minutes," which found this to be an intriguing story. Seeing a rerun of this show was my first exposure to this case.

I am midway through the third and final year of my residency in internal medicine. As a resident, I have experienced some of the most exhilarating moments of my life and also some of the most upsetting. I have never understood, though, how the medical establishment could allow the perpetuation of such an antiquated system of training. Does this system prepare one to deal with the stress of practicing clinical medicine or to make snap decisions on little or no sleep? Does it enhance physician/patient relationships and serve as an effective mode of teaching medicine? Does it show young physicians what the practice of medicine is really all about and convince them that the joys of medicine justify the sacrifices they have made personally and financially? Does it provide them with enough time to develop the other interests and personal relationships that they will need to lend some sanity to their existence? It did none of these for me. But it did

raise serious questions in my mind about an educational system which could and should be providing guidance and a nurturing educational experience for its youngest and most eager members.

Medicine is vastly different from the way it was practiced fifty years ago, and the way we train young physicians must be also, if only to more adequately prepare them to be qualified physicians. The job of the resident today is much more complex than ever before. The current training system primarily serves itself, not the resident in training.

Now that the issue has been unavoidably raised, I hope that the medical establishment, of which I will soon be a part, takes heed to set its house in order. For, if it does not, very soon someone else may.

Members of the Resident Physicians Section of the Illinois State Medical Society have spent a good deal of time considering this issue. While our actions will not alter our experiences, we hope that we can help to reshape the structure of residencies so that they will better serve those who will follow us.

During our eleventh Interim Assembly Meeting held in Atlanta,

Georgia last December, we asked the AMA to vigorously support a series of principles regarding resident working hours. We requested that no resident be asked to take call more frequently than every third night and that one 24-hour period off duty out of every seven days be allocated. We stressed that residents must not bear the financial responsibility for increased costs which may result from these changes, and that the number of years needed to complete a residency program not be increased until these changes have been in effect long enough to evaluate their impact on medical education. The educational mission should not be compromised, we stated, by a routine reliance on resident physicians to fulfill institutional service obligations that can and should be provided by ancillary staff, who must be

available on a 24-hour basis, including weekends and holidays. We noted that adequate backup must be available if sudden or unexpected patient care needs arise, and residents should not provide unsupervised medical care for which they have not achieved competency. Finally, we asked that the delivery of highest quality medical care and the attainment of educational and training objectives be of paramount importance to the institution, attending physicians and physicians-in-training.

It is my hope that the membership of the Illinois State Medical Society will approve our efforts and support them wholeheartedly. And I hope that this support will come from the medical establishment before it is too late. In response to the Zion court decision, the New York Department of Health con-

vened a special task force to investigate the schedules and supervision of resident physicians. The task force recommended a 12-hour limit on emergency room shifts, a 16-hour limit on shifts outside of the emergency room, and breaks in work of no less than eight hours. If adopted, these changes would have a devastating effect on our training. It would turn residencies into shift work. We must work quickly and we must work together, or these changes may be imposed upon us legislatively. Please join us in regaining control of this debate by addressing, not avoiding, the difficult choices which lie ahead. ◀

This article represents the opinion of its author only, and does not reflect the opinions or policies of the Illinois State Medical Society.

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OBITUARIES

****Allerton, Perry, Wayne**, died January 4, 1988, at the age of 90. Dr. Allerton was a 1921 graduate of the University of Nebraska College of Medicine, Omaha.

Balasa, Richard W., Chicago, died October 21, 1987 at the age of 41. Dr. Balasa was a 1973 graduate of the St. Louis University School of Medicine, St. Louis.

***Chiang, Long S.**, Streator, died January 6, 1988, at the age of 46. Dr. Chiang was a 1969 graduate of the Kaohsiung (Takou) Medical College, Kaohsiung, Formosa.

****Christie, John B.**, Champaign, died December 30, 1987, at the age of 79. Dr. Christie was a 1934 graduate of the Northwestern University Medical School, Chicago.

****Dolan, Larsandrew**, Park Ridge, died January 10, 1988, at the age of 77. Dr. Dolan was a 1936 graduate of the Northwestern University Medical School, Chicago.

Esterly, John R., Chicago, died September 25, 1987 at the age of 54. Dr. Esterly was a 1959 graduate of The Johns Hopkins University School of Medicine, Baltimore.

***Gebuhr, Carl A.**, Wilmette, died January 9, 1988 at the age of 74. Dr. Gebuhr was a 1941 graduate of Rush Medical College, Chicago.

****Glenner, Robert J.**, Chicago, died January 11, 1988, at the age of 78. Dr. Glenner was a 1932 graduate of the University of Illinois College of Medicine, Chicago.

****Hays, Verne**, Canton, died August 23, 1987 at the age of 95. Dr. Hays was a 1916 graduate of the St. Louis University School of Medicine, St. Louis.

***Head, Jerome R., Jr.**, Long Grove, died January 20, 1988 at the age of 62. Dr. Head was a 1956 graduate of Northwestern University Medical School, Chicago.

****Horner, Imre**, Beverly Shores, Indiana, died January 31, 1988 at the age of 86. Dr. Horner was a 1933 graduate of Orvosi Fakultás Pecs Tudományegyetem, Pecs, Hungary.

***Hwang, Hyun S.**, Rock Island, died October 4, 1987 at the age of 45. Dr. Hwang was a 1967 graduate of the College of Medicine Seoul National University, Seoul, South Korea.

****Imbierski, Stanley J.**, Chicago, died October 18, 1987 at the age of 88. Dr. Imbierski was a 1924 graduate of the University of Illinois College of Medicine, Chicago.

***Keller, Franklin L.**, Downers Grove, died July 22, 1987 at the age of 61. Dr. Keller was a 1952 graduate of the University of Maryland School of Medicine, Baltimore.

***Jacobsen, Andrew L.**, Downers Grove, died July 31, 1987, at the age of 62. Dr. Jacobsen was a 1952 graduate of the Facultad de Medicina de la Universidad de la Habana, La Habana, Cuba.

***Lawler, Frank C.**, Scottsdale, Arizona (formerly of Chicago), died December 26, 1987, at the age of 78. Dr. Lawler was a 1940 graduate of the University of Health Sciences/Chicago Medical School, Chicago.

****Little, John W. Jr.**, Washington, D.C., died February 7, 1988 at the age of 78. Dr. Little was a 1935 graduate of the Indiana University School of Medicine, Indianapolis.

***Limaye, Shreedhar J.**, Downers Grove, died November 2, 1987 at the age of 53. Dr. Shreedhar was a 1961 graduate of Medical College Baroda University, Baroda, Gujarat, India.

Luisada, Aldo A., Chicago, died November 20, 1987 at the age of 86. Dr. Luisada was a 1925 graduate of Facoltà di Medicina e Chirurgia, Università dell'Firenze, Firenze, Italy.

***Mantz, Harry E.**, Mesa, Arizona, died December 30, 1987, at the age of 76. Dr. Mantz was a 1938 graduate of the Washington University School of Medicine, St. Louis, Missouri.

****McQuiston, William O.**, Peoria, died September 24, 1987 at the age of 79. Dr. McQuiston was a 1934 graduate of the Indiana University School of Medicine, Indianapolis.

Menachof, Stanford A., Franklin Park, died November 18, 1987 at the age of 66. Dr. Menachof was a 1946 graduate of the University of Health Sciences/Chicago Medical School, Chicago.

***Midell, Allen I.**, Chicago, died January 3, 1988, at the age of 53. Dr. Midell was a 1960 graduate of the Northwestern University Medical School, Chicago.

***Mizen, Michael R. Sr.**, Chicago, died January 10, 1988, at the age of 75. Dr. Mizen was a 1943 graduate of Loyola University Stritch School of Medicine, Maywood.

O'Brien, George F., Chicago, died January 11, 1988, at the age of 91. Dr. O'Brien was a 1926 graduate of Rush Medical College, Chicago.

****Robinson, Stanley E.**, Prophetstown, died February 4, 1988 at the age of 81. Dr. Robinson was a 1936 graduate of the University of Illinois College of Medicine, Chicago.

Ruffolo, Hercules, Western Springs, died August 30, 1987 at the age of 89. Dr. Ruffolo was a 1923 graduate of the University of Nebraska College of Medicine, Omaha.

***Runstrom, Richard**, Berrien Springs, Michigan, died January 20, 1988, at the age of 67. Dr. Runstrom was a 1952 graduate of the University of Wisconsin Medical School, Madison.

***Ryan, Donald W.**, Northbrook, died January 1, 1988, at the age of 56. Dr. Ryan was a 1962 graduate of the University of Illinois College of Medicine, Chicago.

Shaw, Maurice M., Chicago, died October 26, 1987 at the age of 81. Dr. Shaw was a 1932 graduate of the University of Illinois College of Medicine, Chicago.

***Silvest, George A.**, Dixon, died February 9, 1988 at the age of 51. Dr. Silvest was a 1962 graduate of the University of Illinois College of Medicine, Chicago.

****Sofield, Harold A.**, Lombard, died December 31, 1987, at the age of 87. Dr. Sofield was a 1929 graduate of Northwestern University Medical School, Chicago.

****Stritar, Joseph E.**, Homewood, died January 19, 1988, at the age of 85. Dr. Stritar was a 1937 graduate of the University of Chicago Pritzker School of Medicine, Chicago.

Turns, James, E., Lebanon, died July 6, 1987 at the age of 59. Dr. Turns was a 1955 graduate of the University of Illinois College of Medicine, Chicago.

Wagner, Wendy L., Chicago, died September 8, 1987 at the age of 42. Dr. Wagner was a 1974 graduate of the University of Illinois College of Medicine, Chicago.

***Waller, George H.**, Decatur, died February 13, 1988 at the age of 70. Dr. Waller was a 1941 graduate of the University of Illinois College of Medicine, Chicago.

***Van Atta, Roger A.**, Ottawa, died February 6, 1988 at the age of 72. Dr. Van Atta was a 1940 graduate of the University of Illinois College of Medicine, Chicago.

***Ward, C. George**, Apple River, died January 21, 1988 at the age of 73. Dr. Ward was a 1941 graduate of the New York University School of Medicine, New York.

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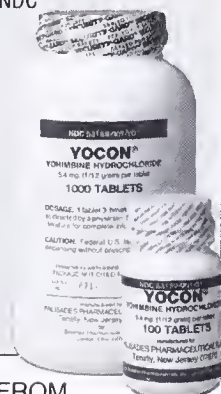
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Bilateral obturator nerve injuries are reported in a patient after urethroplasty secondary to six hour positioning in acute hip flexion. The difficulty was believed to be due to the stretching of the nerve at the bony obturator foramen. Management included steroids, gait training, and avoidance of acute hip flexion. Clinical and electromyographic abnormalities were gone nine weeks later. (Pellegrino, M., Johnson, E.: *Arch Phys Med Rehab* 69:1,46-7, 1988)

Patients with myocardial infarction and recurrent ischemic pain during second hospital day, history of previous myocardial infarct, or ST segment depression on admission electrocardiograms, should be considered for early coronary angiography and possible intervention to prevent extension. The occurrence, outcome, and predictors of myocardial infarct extension were evaluated by the plasma MB creatine kinase activity. Those with elevated creatine kinase activity, indicating extension of the infarct, showed a fourfold higher hospital mortality rate than those without extension, and extension was noted twice as frequently in those with two of the above risk factors. (Muller, J. E., et al.: *Ann Int Med* 108:1,1-6, 1988)

Alcoholism prevalence was assessed on 232 patients in an ambulatory medical clinic by using the Michigan Alcoholism Screening Test. The most sensitive questions appeared to be, "When was you last drink?" at 91.5%, and "Have you ever had a drinking problem?" at 70.2%. The authors suggest these two questions be routinely included in all medical histories, since of the 232 patients, 20.3% were designated as alcoholics on the basis of the Michigan Alcoholism Screening Test. (Cyr, M. G., Wartman, S. A.: *JAMA* 259:1,51-4, 1988)

One hundred forty-two children at 5.9 to 9.5 years had their blood pressure checked at school on one occasion and were retested nine years later under the

same circumstances. Although a significant correlation was noted between initial and subsequent raw systolic pressures in boys and girls, there were wide variations. Therefore any sustained values above the 90th percentile should be considered significant. (Michels, V., et al.: *Mayo Clin Proc* 62:10,875-881, 1987)

Ten male parkinsonian patients approximately 62.2 (+/- 3.8) years with tremor as the most predominant symptom were tested in a double-blind crossover study using long-acting propranolol (160 mg/d), primidone (250mg at night), and clonazepam (4mg/d). Tremor was assessed by patient opinion, clinical scoring, and accelerometer recordings. Propranolol reduced resting tremor by approximately 70% and postural tremors by approximately 50%. Primidone and clonazepam had no significant effect on tremor; primidone was of minimal benefit. No side effects were reported with the long-acting propranolol, which was felt to be a useful adjuvant for the treatment of tremors associated with parkinsonism. (Koller, W., Herbster, G.: *Arch Neurol* 44:9,921-3, 1987)

The plasma levels of amino acids were studied in parkinsonian patients on levodopa therapy and were correlated with the effect on parkinsonian tremors. Seven patients were maintained on the same levodopa medication dose but their dietary intake of proteins was varied. Regular and high-protein diets resulted in marked elevation in the plasma concentrations of large neutral amino acids that competed with levodopa for transport across the blood/brain barrier and increased the parkinsonian symptoms. The authors suggest that Parkinson patients on levodopa therapy maintain a virtually protein-free diet until supper time and then unrestricted allowances until bedtime. This simple dietary manipulation permits near-normal daytime motor function. (Pincus, J., Barry, K.: *Arch Neurol* 44:10,1006-1009, 1987)

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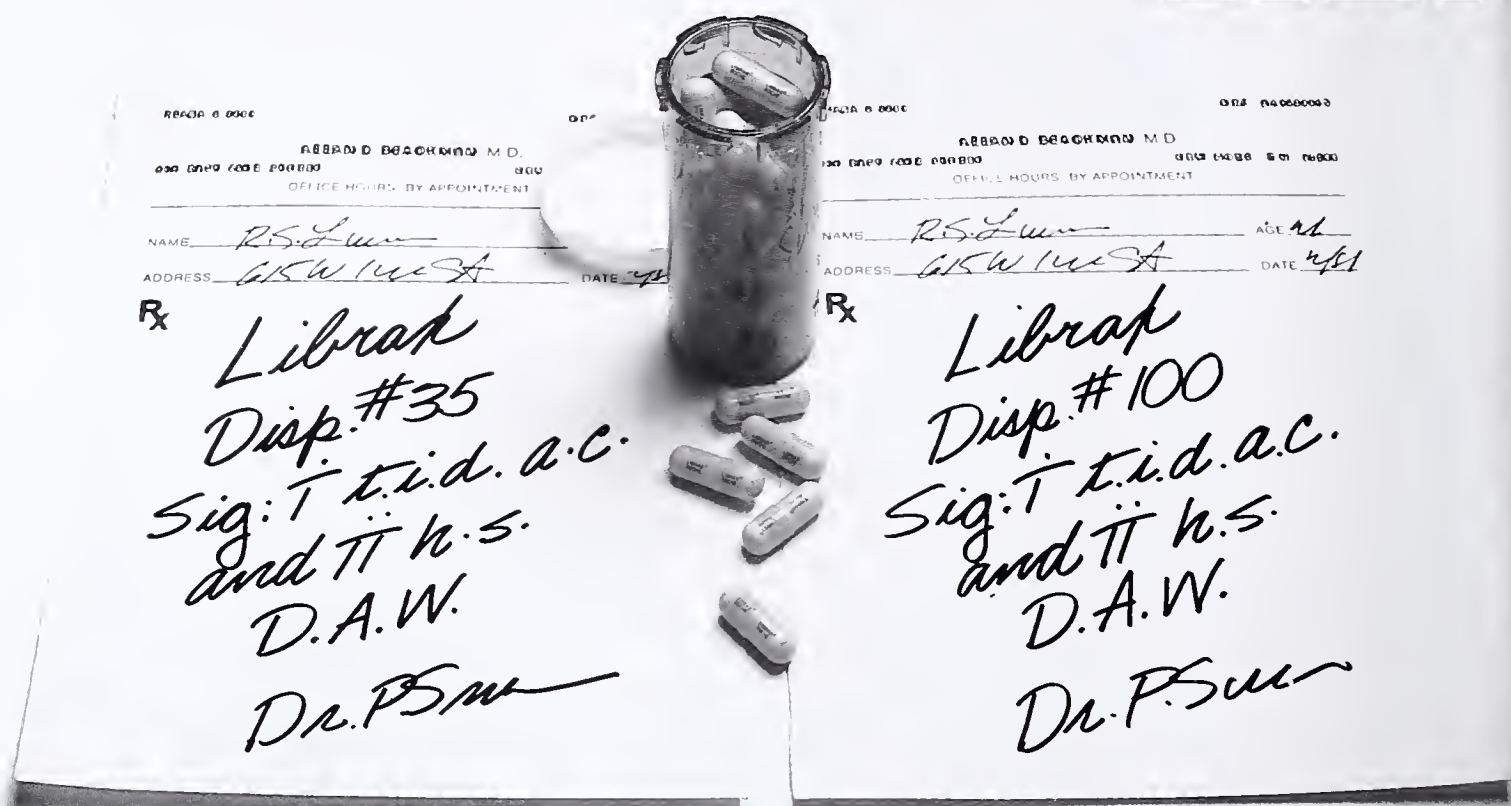
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Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

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As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS

Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS

In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring. In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class. Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS

Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued. Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS

Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.

Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur.

DOSEAGE AND ADMINISTRATION

Therapy should be initiated with application of one Transderm-Nitro 5 mg/24 hr system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.

The usual dosage is one Transderm-Nitro 5 mg/24 hr system. Some patients, however, may require the Transderm-Nitro 10 mg/24 hr system. If a single Transderm-Nitro 5 mg/24 hr system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 mg/24 hr systems or one Transderm-Nitro 10 mg/24 hr system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 mg/24 hr system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone. The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs. Do not store above 86°F (30°C).

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ISMS Physician Games Scheduled

Attention All Personnel!

By WILLIAM J. MARSHALL, M.D./OLYMPIA FIELDS
MEMBER, ISMS PHYSICIAN GAMES COMMITTEE

The fourth annual ISMS Physician Games will be held at the Oak Brook Hills Hotel and Conference Center on Friday and Saturday, June 24-25. All members and their spouses are encouraged to attend the events, which include activities for all interests and energy levels.

- What stuffed animal did Radar O'Reilly sleep with?
- Can you name Margaret Houlihan's husband?
- How about Colonel Potter's horse?

These and other fascinating facts are yours to discover even if you don't choose to attend the Friday morning clinical session of the ISMS Physician Games weekend.

We all advise our patients to eat properly, adopt sensible weight-reduction programs and exercise regularly. Here's a chance to practice what you preach!

The fourth annual ISMS Physician games will be held June 24 and 25 at the highly accessible Oak Brook Hills Hotel and Conference Center, a beautiful new hotel and sports facility.

We'll start with a clinical program, move quickly into athletic competition and celebrate medical camaraderie with a MASH-theme dinner dance.

On Friday morning, June 24, a clinical program on the health effects of cholesterol will begin at 9:00 a.m. Basil Rifkind, M.D., chief of the lipid metabolism-atherogenesis section at the National Institutes of Health, will present the keynote address. Dr. Rifkind will consider the effect of serum cholesterol on

blood vessel disease, office testing options and patient management issues.

The second speaker on the four-hour Category 1 CME program is Linda Van Horne, Ph.D., R.D., assistant professor, Department of Community Health and Preventive Medicine, Northwestern University Medical School. Dr. Van Horne will discuss the role of diet in hyperlipidemia, with emphasis on use of fiber and other nutrients.

William Lands, M.D., of the department of biochemistry at the University of Illinois, Chicago, will address recent research on the effects of aspirin and fish oils on cardiovascular health. Michael Davidson, M.D., of Rush-Presbyterian-St. Luke's Medical Center, will conclude the clinical section of the program with a presentation on the role of medication in treatment of elevated cholesterol levels.

My colleagues on the Physician Games Committee, chaired by Craig Dean, M.D., and assisted by Nelson Borelli, M.D., Arvind K. Goyal, M.D., and Anthony Ivankovich, M.D., have been busily polling sports enthusiasts and planning accordingly.

Friday afternoon activities will include a golf tournament and singles tennis for men and women.

That evening, participants are invited to attend a MASH-theme dinner dance. Costume is compulsory. We'd like to see a few Hawkeye, Hotlips and Radar look-alikes, although scrubs or fatigues will do.

Prizes will be awarded for best male and female costumes. A MASH trivia contest will challenge even the staunchest fans. We expect a great evening.

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Physicians Warned About Prescription Contests

ISMS has become aware of promotional activities by drug manufacturers to increase their markets by offering physicians points or prizes for participating in activities which include prescribing their products. It is the opinion of ISMS legal counsel that participation in such activities could place a physician's membership and license in jeopardy.

The Illinois Medical Practice Act of 1987, which gives the state the authority to license and discipline physicians, provides that:

"Promotion of the sale of drugs, services, appliances or goods provided for a patient in such manner as to exploit the patient for the financial gain of the physician [is grounds for discipline]."

Participation in a drug manufacturer's promotion which awards points or prizes to physicians may not necessarily be deemed as a violation of this section. However, at the very

least, questions may be raised as to whether the drug being prescribed to a patient is the best drug for the patient's condition, if it is more expensive than alternative drugs, or if the patient even needs the drug.

In addition, there are other disciplinary grounds listed in the Medical Practice Act which may apply. These sections include: (1) Breaching the physician-patient confidential relationship (for sending in the patient's name and medical information to the drug manufacturer); (2) Accepting fees for services not actually provided (points and prizes); and (3) Using prescriptions for nontherapeutic reasons (to gain prizes).

The most significant danger to the physician who is or would consider participating in the program is that it creates the *appearance* of the violation of several disciplinary grounds.

There also are ethical considerations raised by the American Medical Association Principles of Medical Ethics and the ISMS Code of

Ethics. These identical documents speak to "dealing honestly with patients" and providing "competent services."

The prescribing of drugs for prizes would also appear to violate several decisions of the AMA's Council on Ethical and Judicial Affairs, which state that: (1) Reputable drug firms should rely on quality to sell their drugs and not appeal to a physician's financial interests; (2) A physician should not be influenced in the use of drugs by a direct or indirect financial interest in the drug firm; and (3) A patient should have the right to have a prescription filled by the provider of his choice.

In light of the above potential problems associated with this activity, specifically, the conflicts between the physician's personal financial gain and the patient's medical needs, physicians should be extremely cautious in participating in such programs. ◀

How the Auxiliary Network Worked for You

By LYNN KASSEL (MRS. WAYNE), ISMSA PRESIDENT

When my year as president began in April 1987, auxiliary network opportunity was the focus. The process was demonstrated through district meetings, which met specific ISMSA county program requests. AMA Auxiliary materials were used along with ISMSA programs during our Annual Meeting and Fall Conference as well.

Our network also included outside related programs that met county needs. The "ICARE" drunk driving program, originated by emergency room nurses, was part of a Fall Conference workshop and was implemented in two counties. One hundred copies of the Martha Rounds exercise tape, "Sit and Be Fit," were purchased and mailed free to each county auxiliary for use in their communities with space allocated for a county auxiliary tag. Member involvement in ISMSA policy-setting was demonstrated through this action, the result of a 1987 resolution.

Visiting the counties with President-Elect Sherry Betsill provided insight into auxiliary community programs. A cooperative spirit was evident on our visits, as we saw how member consciousness of the AMAA, ISMSA and county auxiliary networks is growing.

Our new membership brochure was designed to enhance the county's efforts toward recruitment and retention of members. The final move of state financial services to the ISMS headquarters office is expected to expedite our membership recording. By now members should have received their first ISMSA membership cards mailed with the Annual Meeting invitation. If your spouse did not receive one, check with the county treasurer to verify that dues have been received.

The ISMS continues to support us through staff services. They have invited auxiliary involvement in their media campaign on youth health issues, something we are prepared for and looking forward to. Mailing copies of the Pulse page in the *Illinois Medical Journal* and our newsletter "Pulse" to county medical society presidents and executives aids in awareness of auxiliary. Our statewide Doctor's Day project is an attempt to say thank you and to make the public look positively toward medicine.

How It Worked for Me

As president of ISMSA it was gratifying to watch the auxiliary network. Witnessing the development

of an idea such as the Adolescent Sexuality Workshop from a 1987 Annual Meeting resolution to its November 6th reality was exhilarating. Our chairmen produced a quality professional program on a low budget. Access to this event has been secured through videotape, and will be showcased at our 1988 Annual Meeting. The auxiliary network choreographed an idea into a community health program. Assistance was provided by the communications/journalism department of the College of St. Francis in Joliet. The counties will use the program in their communities, moving the network into all parts of Illinois.

Traveling the state has made me aware of the level of dedication and sincerity of our leadership. The cooperative spirit mentioned earlier was evident in the compliance to requests for increased participation in donations to AMA-ERF through the Sharing Card (six new counties joined in this project). The 1987-1988 Board of Directors and I take great pride in our volunteers and look forward to greeting them at our Annual Meeting, where we will celebrate the 60th year of our state organization. Everyone worked hard this year. Come and enjoy the fruits of our labor. ◀

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Changing Perspectives in Substance Abuse and the Physician's Role

By AMIN N. DAGHESTANI, M.D./MAYWOOD

Alcohol and other drug abuse continues to be a major public health problem. Recent epidemiologic and socioeconomic trends, as well as changes in drug abuse patterns toward polyaddiction, have led to a re-examination of the physician's role and responsibilities. Insurance coverage, the matching of patients with treatment modalities, and the treatment of dually addicted psychiatric patients are some of the challenges that will continue to face physicians in the future.

Approximately 10.6 million adults in this country can be classified as alcoholics, and an additional 7.3 million either abuse alcohol or have experienced negative results of alcohol use, such as arrest or involvement in an accident.¹ In addition to the various medical problems of cirrhosis, pancreatitis, hypertension, and nutritional deficiencies, consequences of problem drinking include injury, homicide, suicide, family abuse, and other violence. Statistics from other drug dependencies, although not as readily available, point to similarly widespread adverse effects.

Physicians are asked to play an increasingly important role in the management of patients with addictive disorders.^{2,3} An awareness of recent trends and their treatment implications should make the physician's role central to successful intervention in patients with substance abuse problems.

Epidemiologic Trends

The elderly and the adolescent populations are increasing their rate of alcohol and other drug abuse to adult levels. The elderly, many with diminishing physical stamina and social resources, are

particularly vulnerable to substance abuse. The impact of substance abuse on teenagers is substantial, considering its potentially adverse effects on the emotional, social, and physical development of the adolescent. Currently, adolescent problem drinkers are estimated to number 3.95 million.

Substance abuse in pregnant women is of particular risk for both the mother and fetus. Although fetal alcohol syndrome was described many years ago, only recently have the effects of drugs, such as cocaine, become clear.⁵

Professionals who work in health care, such as physicians and nurses, constitute a high risk group for developing substance abuse.⁶ Other populations at risk are listed in Table 1.

Socioeconomic Trends

Public awareness of alcoholism and other drug dependence has risen significantly over the last 10 years. A media campaign was developed portraying substance abuse as a major public health issue. Stiffer legal penalties for drunk driving offenses (DUI) have been implemented. Attention has also been drawn to the problem of drug abuse among minorities such as blacks and Hispanics, many of whom are

Table 1
Populations At Risk Of
Developing Substance Abuse
Problems

- 1. Health Care Professionals**
Physicians
Nurses
Medical Students
- 2. High Stress Occupations**
Air Traffic Controllers
Stockbrokers
- 3. Children of Alcoholics**
- 4. Patients with a history of multiple hospitalizations or operations in childhood.**

viewed as particularly susceptible to substance abuse.

Intravenous drug abusers are among those populations at high risk for developing acquired immune deficiency syndrome (AIDS). Whether this fact will lead to a decrease in the prevalence of drug abuse in general, a decline in intravenous drug administration, or have no effect at all is as yet undetermined. A study to investigate these possibilities could invariably yield important epidemiologic findings.

The adverse effects of alcohol and other drug abuse on industry have been recognized. The Alcohol, Drug Abuse and Mental Health Administration estimates that alcohol and drug abuse costs nearly \$100 billion in lost productivity each year.⁷ The role of the supervisor with problem drinker employees was re-examined,⁸ and many companies found it beneficial to establish employee assistance programs (EAP). The question of urine testing at the workplace has become a subject of heated debate at the highest levels in government, national sports, and politics.⁹ The American Occupational Medical Association in 1986 issued specific guidelines for drug screening in the workplace to insure proper utilization of such testing.¹⁰

Perhaps most emotionally-charged of all societal issues related to alcohol and drug abuse is that of child abuse. Physical, emotional, and sexual abuse of children can be attributable to adult substance abuse.

Changing Patterns

Twelve million Americans use cocaine at least once a year, and six million are current users. In five years, cocaine-related deaths and emergency room visits have tripled. Cocaine abusers represent an increasingly larger segment of inpatient admissions.¹¹ One method of preparing cocaine (freebase), and a cheaper and more readily available form of the substance (crack) have contributed to cocaine's high addictive rate.

On the other hand, nicotine dependence showed a significant decline in this country between 1964 and 1985. Prevalence has

dropped from 45% to 30% for persons 18 years of age and older, but the gap between male and female smokers is narrowing.¹² Nicotine chewing gum was introduced, however, the extent of its effectiveness or the exact role it plays in the outcome of long-term treatment of nicotine dependence is yet to be determined.

Other abused drugs declining in popularity include hallucinogens and certain drug "combinations" such as "T's and blues" (pentazocine and tripeleennanline).

Considering all patterns of drug abuse, the most significant phenomenon currently observed is the tendency toward polyaddiction. More patients are presenting for treatment with multiple substance abuse. Alcoholics often report the use of sedative-hypnotics, while other drug addicts describe more frequent and concurrent consumption of alcohol.

The Proliferation of Self-Help Groups

Numerous self-help groups have been formed in the last few years. Their aim has been primarily supportive. For the most part, these groups have adopted the same principles which were set earlier by Alcoholics Anonymous. Groups include gamblers, people with eating disorders, and sexual addicts. Many of these programs utilize concepts which have proved useful in understanding the family dynamics of the addict.

Other terms such as "co-dependency" may have been hastily introduced, and not fully supported by research data. One questions the need for introducing the co-dependency term when a diagnosis of adjustment disorder is already in place in the *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-III-R)*.¹³

Recent Understanding of the Concept of Addiction

The term addiction, following a brief lull in its usage, is regaining its popularity in literature. This is due, in part, to the fact that no specific chemical name is attached to it, hence, less emphasis is placed on the choice of a specific drug of abuse and more on the condition

itself. The concept is further supported by the recent observation of the shift to polyaddiction (the abuse of two or more substances), and sequential addiction (switching from one substance abuse to another).

Common characteristic factors tend to link alcohol and substance abuse on one hand and other pathological behaviors on the other. Compulsive gambling, eating disorders (anorexia nervosa, bulimia), compulsive spending, lying and sexual addiction are seen as defensive behavior against intolerable and painful affects. The addict uses them as a way of dealing with the harsh demands of reality. Other commonalities include poor impulse control, compulsivity, and polysymptomatic clinical presentations. The natural history of these disorders, furthermore, share a chronic and rather progressive course.

In general, addicted patients have a specific deficit in tension-regulating mechanisms. Healthier sublimatory defense mechanisms are poorly developed. Instead, more primitive defenses such as projection or all-or-none phenomenon are utilized. Due to this regulatory deficit, tension generated by the requirements of daily life can not be dealt with on a timely or gradual fashion. Unpredictable episodes of intense discharge of tension ensue, sometimes taking the form of violent and irrational behavior, leading to further perpetuation of the cycle of abuse.

Khantzian¹⁴ described a similar hypothesis of self medication. He saw the addict's use of drugs as an attempt at self-medication against painful affects.

The Role of the Physician

Physicians competent in treating alcoholics must periodically update their clinical knowledge and skills, not only in the area of withdrawal treatment, but in other aspects of long-term psychosocial management of substance abusers as well. Special continuing medical education (CME) seminars are available for this purpose.

At the undergraduate level, medical student education should specifically address the question of stu-

dent and physician vulnerability to substance abuse. Conferences held at Illinois medical schools addressing medical student impairment have been suggested.¹⁵

Increased research in the diagnosis and treatment outcome of alcohol and substance abuse will provide a basis for recognition of these conditions. Residency training programs offer a great opportunity to build a strong foundation for the training physician to improve his or her knowledge, skills, and attitudes toward helping addicted patients.

The question of stereotyped and often negative attitudes toward substance abusers continues to pose a problem for some physicians. A re-examination of such attitudes, and the adoption of an open, non-judgmental and non-moralizing approach, should improve the communication between doctors, patients and their families, and contribute to a positive patient/doctor relationship. Physicians could provide necessary education about the disease concept of alcohol and drug abuse and the treatment modalities of these disorders. Such an education should lead to reducing the social stigma attached to addicted patients.

In dealing with substance abusers in various clinical settings, physicians often find themselves working hand in hand with professionals from other disciplines. In addition to social workers, psychologists and nurses, others who play an important role in substance abuse are mental health workers, clergymen, individuals from the legal system and volunteers from self-help groups. For a well-coordinated multidisciplinary approach, physicians ought to take a leading role in the treatment team. They need to communicate effectively and directly with all team members. Knowledge of certain Alcoholics Anonymous (AA) concepts and street drug terminology should facilitate this communication. In addition, a variety of available support from self-help groups could be incorporated in the overall treatment plan.

The question of who among physicians should primarily treat the addicted patient is a topic which is currently under discussion. Physicians from various specialties and

different clinical settings involved in care and treatment programs originally designed for patients with a single abuse are now accepting polydrug abusers. To reflect this shift, programs have changed their names to emphasize the treatment of chemical dependence or substance abuse in general.

Challenges Ahead

Presently, a number of challenges are facing physicians in this field. The way these challenges will be dealt with will eventually determine the usefulness of the theories, as well as the effectiveness of the treatment modalities and approaches currently utilized. The following is a list of some of the issues in question:

■ Insurance coverage.

In comparison to the staggering economic toll resulting from the addictive disorders, the amount of insurance coverage and third party payment continues to lag far behind. Further studies to reflect the eventual economic savings with treatment should extend the coverage to all who are in need of treatment.

■ Matching of patients with treatment modalities.

Although the indications for inpatient versus outpatient treatment have been clarified,¹⁶ the matching of a specific treatment modality (*i.e.*, individual, family, or group therapy, newer medications) to a patient's needs continues to lack a much-needed cohesiveness. Further research may delineate different patient subpopulations who will respond to specific treatment approaches.

■ The treatment of the addicted psychiatric patient.

Patients with addictive diagnoses as well as a co-existing major psychiatric problem, such as schizophrenia or bipolar disorder, constitute a patient group which is grossly underserved at the present time. Despite their compounded problems, these patients do not easily fit into programs designed to treat primarily a psychiatric or addicted population. A novel approach which effectively combines services for those patients is sorely

needed. Obviously, training of professionals in such interventions forms the first step in this effort. Further research is needed regarding the prevalence of co-existing psychiatric illness and the impact of these conditions on traditional substance abuse treatment.

Summary

Physicians and substance abuse treatment centers are being confronted with the necessity to re-examine the basic models they have been operating under in the last 20 years. Recent patterns in drug abuse must be considered in such a review process. Many challenges for the physician in this field lay ahead.

Various biological therapies (such as naltrexone and antidepressants), psychotherapeutic techniques, psychosocial interventions, and social support systems need to be incorporated and well-coordinated. The primary aim of such an approach is to maximize treatment outcome in a cost-effective manner.

For physicians to be able to meet these expectations, a thorough education at all levels and intensive research will be required. In order for the physician's intervention with addicted patients to be successful, they should assume a leadership role in all of these efforts. ◀

Acknowledgements

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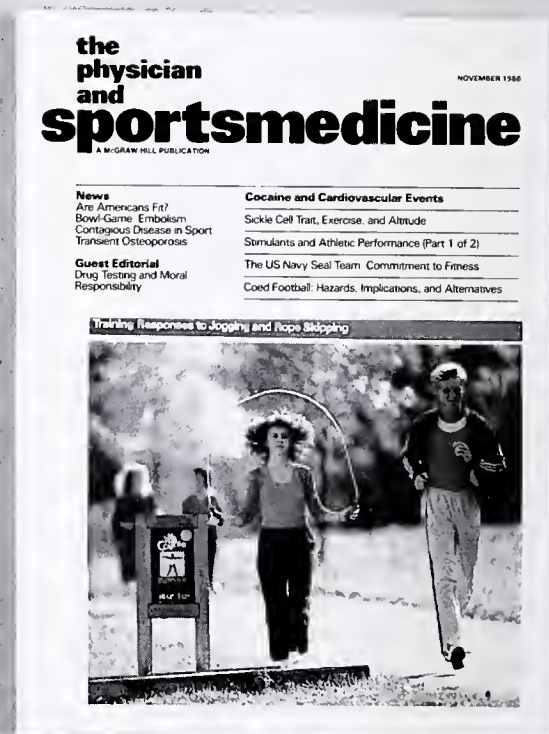
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An Unusual Cause of Breast Mass in a Male

Cysticercosis

BY REGINA G. PALOYAN, M.D., DIANE V. DADO, M.D., AND
ALIREZA ARMIN, M.D./MAYWOOD

A 56-year-old businessman who had recently travelled to Mexico presented for evaluation of an asymptomatic unilateral breast mass. The patient's physical examination and preoperative workup were unremarkable. The mass was excised and a cystic lesion was found embedded in the pectoralis major. Upon histologic examination, the cyst proved to be *Cysticercus cellulosae*. Parasitic infections should be considered in the differential diagnosis of asymptomatic masses in a patient who has travelled to developing countries.

Breast disease is an unusual occurrence in males. When a discrete mass occurs in the male breast, carcinoma is part of the differential diagnosis until proven otherwise by excisional biopsy. We present an unusual case of cysticercosis, which is the larval form of *Taenia solium*, presenting as an asymptomatic breast mass in a 56-year-old male evaluated for excisional biopsy. Although this parasitic disease is endemic in third world countries and has previously been rare in the U.S., it has recently become more prevalent and has the potential to become endemic in this country.^{1,2}

Case Report

A 56-year-old male was referred for excisional biopsy after his private physician discovered a breast mass on routine examination. On presentation an asymptomatic, firm, mobile mass, present for an indeterminate length of time, was

Figure 1



Figure 1A. Muscle with intact cyst wall and larvae.

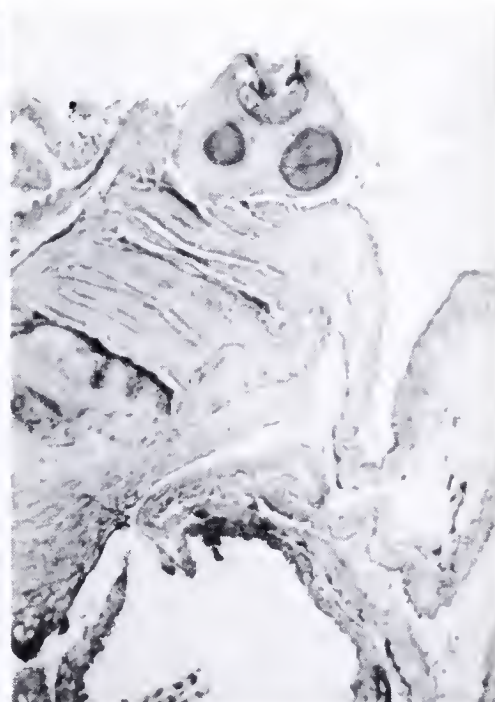


Figure 1B. Section of *Cysticercus cellulosae*, demonstrating characteristic rostellum with hooks.

palpable in the upper, outer quadrant of the breast. The overlying skin was not involved. The rest of the physical examination and pre-operative workup was unremarkable. At surgery, a firm, three-centimeter mass was found within the pectoralis major muscle. The mass was removed with a rim of muscle tissue and the wound was closed in layers. A frozen section, performed on the muscle tissue at the time of surgery, revealed myositis with atrophy. Permanent section confirmed the chronic myositis and also revealed a mass consisting of a fibrous-walled cyst enclosing a fluid-filled center with *Cysticercus cellulosae*. The patient had no other palpable masses or systemic involvement and was to be followed-up closely by the infectious disease service.

Pathology

Permanent section of the specimen revealed a cyst with a white, thick, multilayered fibrous tissue wall and an extensive foreign body inflammatory reaction. The lining layer was yellow in color with minute bumps. The cyst cavity was filled with straw colored fluid. In the center was *Cysticercus cellulosae*, which is the larval form of *Taenia solium*. It had the characteristic rostellum with hooks, not seen in *Taenia saginata*. (Figure 1)

Discussion

Our patient presented with a firm mass that appeared to be in the upper outer quadrant of his breast tissue. Although the initial differential diagnosis included breast carcinoma, suspicion of malignancy remained high even at operation, when the mass was found to be in the muscle.³ A mass due to a parasitic systemic infection was not even considered until the cyst was opened for permanent section. Only at this time was a travel history to Mexico within the last 12 months elicited. Although systemic infection with the adult tapeworm or larval form of cysticercosis is rare in the United States, it is endemic in our southern hemisphere, Africa and India, and is the most common parasitic brain disease in the world.^{1,2}

Intestinal infestation of a prima-

ry host (man) with the *Taenia solium* tapeworm, which often are two to seven meters long, occurs from ingesting the cysts in inadequately cooked pork. The cyst wall is degraded in the stomach, the head of the tapeworm attaches to the jejunal mucosa and tapeworm eggs pass with the feces to contaminate the soil. The intermediate host (the pig) ingests the eggs and the ingested larvae penetrate the gut wall, enter the bloodstream and develop in other tissues.^{1,2,4} The larvae have a predilection for skin, skeletal muscle and the central nervous system.⁴ Humans can become an intermediate host (as our patient was) by ingesting *Taenia solium* eggs in fecally contaminated water or food or through autoinfection.^{1,4}

Patients with cysticercosis can be asymptomatic if the larvae are located in non-strategic body tissues.^{5,6} Twenty to fifty percent of patients are without symptoms.^{4,5} Others present with headaches, seizures, ataxia, confusion, nausea and vomiting with cerebral involvement and myalgias when there is muscular involvement.^{2,7,8} Diagnosis is often times based on a high index of suspicion. A CAT scan of the head may show the cysts, if the larvae are alive, or characteristic punctate calcifications after the larvae die.^{1,5,6} Serologic testing by indirect hemagglutination is not specific enough to diagnose cysticercosis, as false positive and negative tests frequently occur.^{1,9} A definitive diagnosis is only possible with excisional biopsy of an accessible lesion.

Treatment of the disease includes removing accessible cysts and treating symptoms as they become apparent (surgically decompressing hydrocephalus, antiseizure medication, steroids, etc.).² Recently, reports of success with the antitrema-tode medication, praziquantel (originally designed to treat schistosomiasis), have appeared in other countries.^{1,6} This drug, not yet approved for the treatment of cysticercosis in the United States, needs further testing to determine dosage schedules and length of treatment course, as it is not without significant side effects.^{1,5,6,10}

Summary

Cysticercosis, or the larval form

of *Taenia solium*, presenting in a middle-aged male is an unusual cause of a breast mass. A history of travel to Mexico, where the disease is endemic, explained the occurrence of the disease in the larval form in our patient. Treatment consisted of excision of the accessible lesion. The patient continues to be asymptomatic six months later.

Transmission of cysticercosis within the United States has been documented in Los Angeles. With increasing travel and immigration from southern hemisphere and other third world countries, cysticercosis can be expected to increase in this country.¹ Travel history should become part of the medical history. Parasitic disease should be included in the differential diagnosis of cystic lesions in the soft tissues.

Acknowledgement

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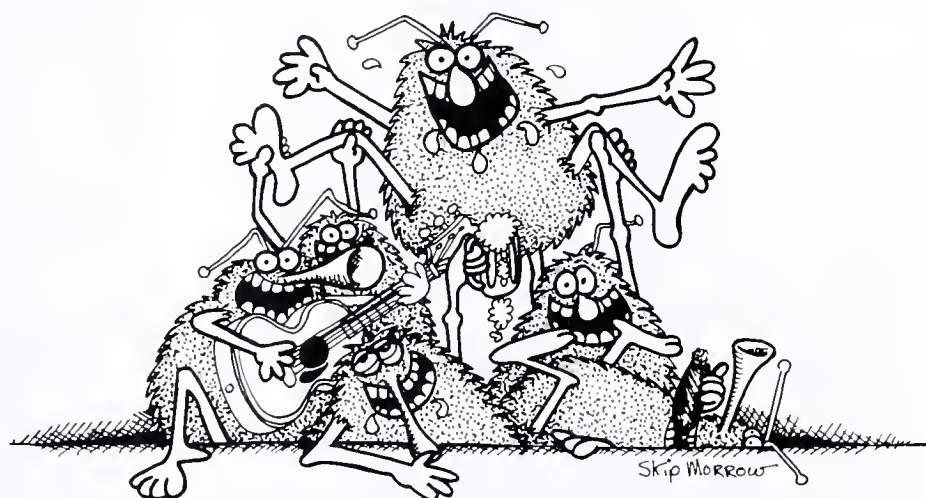


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Hemolytic Uremic Syndrome

BY DENNIS R. CAFFERY, M.D./PEORIA

Hemolytic uremic syndrome (HUS) is a disease characterized by anemia, thrombocytopenia and renal failure. It is preceded by a prodrome illness. HUS is not a rare disease, but it must be recognized by the primary care physician in order to start appropriate treatment.

Hemolytic uremic syndrome (HUS) was first described by Glasser, *et al.*, in 1955.¹ HUS is characterized by a triad of features: acute renal failure, microangiopathic anemia and thrombocytopenia.^{1,2} At clinical presentation one of these features may be lacking while others may vary in intensity.²

HUS has developed in a variety of clinical settings ranging from pregnancy to infancy.^{2,3} However, the most typical presentation is in a child one to four years of age who has a prodrome of diarrhea (often bloody) progressing to renal failure, anemia and thrombocytopenia.^{2,4,5}

Although HUS is not a common disease, many primary care physicians will have contact with a case in their careers, and should be able to make the diagnosis when there is a typical presentation. Early recognition will avoid unnecessary diagnostic testing and facilitate rapid and appropriate referral and treatment.

Case Presentation

A 22-month-old boy was transferred to a medical center for further evaluation of gastroenteritis. His medical history was unremarkable except for inadequate immunizations with only two DPTs. He was well until six days prior to admission

to the medical center, when he began having liquid green diarrhea with some hematochezia. He was started on amoxicillin for his diarrhea three days prior to admission and, except for the diarrhea, had no other complaints. He maintained an adequate oral intake. Two days prior to admission to the medical center he presented at an outlying hospital with persistent diarrhea, decreased urination and vomiting. He was admitted with a diagnosis of gastroenteritis and dehydration. Physical exam at that time revealed a temperature of 100.4 rectally, a benign abdomen and negative rectal exam. He was treated with trimethoprim and sulfamethoxazole orally and intravenous rehydration solutions. Over the next two days he continued to have three to six greenish liquid stools per shift with frequent emesis, and continued to run a low grade temperature. Laboratory tests from the outlying hospital showed an increase in WBCs from 15,400 to 23,600, a drop in hemoglobin from 14.1 to 10.5 and a decrease in platelets from 411,000 to 100,000 over two days. His electrolytes showed a dropping potassium and bicarbonate with a falling blood pH. Urinalysis was normal and stool cultures showed normal flora. He was then trans-

ferred to our institution for further evaluation.

More detailed history failed to reveal any recent travel, unusual food or other diarrheal illness in the family. The child was alert but pale, and was found to have an elevated systolic blood pressure of 120 with a temperature of 101.0 rectally. He had some edema of the eyelids, but none elsewhere. Abdominal exam revealed tympanic bowel sounds but no distention or tenderness. He did have Hematest positive stools.

Chest and abdominal x-rays along with sonography suggested a possible intussusception. Barium enema was performed which showed mucosal changes consistent with colitis or ischemic bowel. It was felt he did not have a surgical abdomen.

The child remained stable throughout the day following admission but had persistent diarrhea as well as dry heaves. He remained somewhat listless and developed edema of the hands. Late in the day he was noted to be anuric for six hours despite adequate IV fluids. Laboratory data showed an increase in BUN from 39 on admission to 49 late in the day following admission. His sodium had fallen to 130 and potassium had risen to 5.1. A 12-channel chemistry revealed a creatinine of 3.5, a total protein of 3.7, an albumin of 2.0, an LDH of 2,534, an SGOT of 138 and a uric acid of 9.9. Stool cultures again revealed no pathogens. After examination of the data collected over

the past 20 hours since admission, a presumptive diagnosis of HUS was made.

At this time the patient was transferred to a pediatric intensive care unit at another hospital for further evaluation where he remained for 16 days. Treatment consisted of plasmapheresis and hemodialysis for acute renal failure. This eventually was switched to peritoneal dialysis. He remained anuric for 12 days, but by the sixteenth hospital day he had an adequate urine output. His course was complicated by anemia requiring transfusion, transient seizures, transient hypertensive episodes and thrombocytopenia with a platelet count as low as 44,000.

Peritoneal dialysis was stopped on the sixteenth hospital day as his renal function was improving. He remained mildly anemic, but his platelet count had returned to normal. The patient was discharged on the twenty-second hospital day with improving renal function and a prognosis for complete recovery and nonrecurrence.

Discussion

Hemolytic uremic syndrome (HUS), thrombotic thrombocytopenia purpura (TTP), and the disorders between these entities represent a spectrum of terminal pathologic processes.^{2,6} At times there is overlap between TTP and HUS, although HUS usually affects a younger patient and has a better prognosis.²

The exact pathogenetic mechanism which results in the clinical picture of HUS is not known.^{2,6-9} In some cases there appears to be an endotoxin which damages the endothelium of blood vessels, resulting in platelet aggregation and microvascular hemolysis.^{2,6,7} Researchers have found a platelet aggregating factor as well as an increased titer of factor VIII-Von Willebrand factor in some HUS patients.⁸ A deficiency of prostacyclin, which is a vasodilating and an antiplatelet aggregating substance, has been found inconsistently in some HUS patients.^{6,9} Unfortunately, there is probably a cycle of microvascular thrombosis followed by hemolysis, which triggers further thrombosis and the release of more aggregating fac-

Table 1

Forms of HUS	Description
Classic	Affects children less than 3-4 years old. Prodrome is that of bloody diarrhea. Prostacyclin function is usually maintained. Verotoxin producing <i>E. coli</i> may be an inciting agent. Prognosis is usually good. Usually not recurrent.
Postinfectious	Etiologic agents such as <i>Shigella</i> , <i>S. pneumonia</i> and <i>Salmonella typhi</i> are found. Endotoxemia and DIC may be present. Worse prognosis. Usually not recurrent.
Hereditary	This may be autosomal dominant or recessive. Occurs at any age. May be recurrent. There may be prostacyclin synthesis or activity dysfunction.
Immune pathogenesis	There is low plasma C3 with activation of the alternate pathway and glomerular C3 deposits.
Association with other illnesses	Such as SLE, scleroderma, malignancy, hypertension, etc.
Associated with pregnancy	Related to pregnancy or contraceptive use.

tors.²

Various etiologic agents have been associated with HUS. Viruses such as coxsackie, ECHO, and adoviruses have been demonstrated by culture or titer change in HUS patients.² Even more common is the association of *Salmonella* and *Shigella* with HUS.² (Pneumonococcal URI has rarely been the prodrome for HUS.²) When HUS affects adults it is commonly associated with oral contraceptives or pregnancy.^{2,3} Individuals with hereditary forms may have specific biochemical markers, but the etiology of inciting events is uncertain.^{2,7} Verotoxin producing *E. coli* (VTEC) has been grown from stools of HUS patients who previously were classified as having idiopathic HUS.^{2,10} Experimental models have shown a similarity between the endotoxin produced by VTEC and the endotoxin of *Shigella*.¹⁰⁻¹² Unfortunately, VTEC is not identified on routine stool cultures and stool samples must be sent to reference labs.

Because HUS has such a heterogeneous nature, it has been difficult to further classify this syndrome. Kaplan, *et al.*,⁷ have proposed a classification scheme for the different types of HUS. (Table 1). Although this classification is not definitive, it does help organize the wide spectrum of clinical presenta-

tions of HUS.

Clinical Presentations

The clinical picture of HUS can be quite variable, but in general, there is a prodrome of diarrhea with or without bloody diarrhea and vomiting.^{2,10,13} A nondiarrhea prodrome will present in less than 10% of cases.¹³ A history of diarrhea in other family members is present about 25% of the time.¹³ Mild cases of HUS may have mild azotemia, anemia and thrombocytopenia with an uncomplicated course.^{2,13} Others may develop anuria lasting from days to weeks, sometimes progressing to chronic renal failure. Hypertension, jaundice, petechiae and dehydration also are found in less than 25% of HUS patients. Central nervous system involvement may indicate a more severe case of HUS, with neurologic manifestations ranging from the more common seizures to the less common personality changes, coma, hemiparesis and dizziness.^{2,14} Although cerebral microthrombi have been found, electrolyte and other chemical abnormalities may be responsible for some of the neurological manifestations.^{2,14}

HUS occurs most frequently during summer months, with an annual incidence of nearly one per 100,000 in one study.^{4,5} Seventy

percent of the cases of HUS occur in children under age five, with a mean age of one to four years.^{4,5} It appears to be an endemic disease with some groups of cases closely related in time.^{4,5} Males and females are affected equally. The mortality rate has continued to fall over the last 20 years, probably due to a better understanding as well as improved treatment of HUS.⁵ In one large study, 73% of patients recovered completely, 15% developed residual renal impairment and about 5% died.

Summary

Treatment for mild forms of HUS is largely supportive.² In more severe forms of HUS plasma infusion as well as plasmapheresis have been used, presumably adding a deficient factor to the blood or removing a toxic substance from the blood.¹⁵ Hemodialysis and peritoneal dialysis are being used for those patients in renal failure.¹⁶

In summary, HUS is a clinical entity generally presenting with the triad of anemia, thrombocytopenia and renal failure with variable severity. Our patient with HUS had a classical presentation of the disease with a prodrome of bloody diarrhea and no etiologic agent found. These patients can often be a diagnostic dilemma because of the systemic nature of the disease. In fact, it is not unusual for some HUS patients to undergo exploratory laparotomy for a presumed acute surgical abdomen.¹² Physicians need to keep HUS in mind for those patients in the proper clinical setting, in order that correct supportive treatment can be started promptly. ◀

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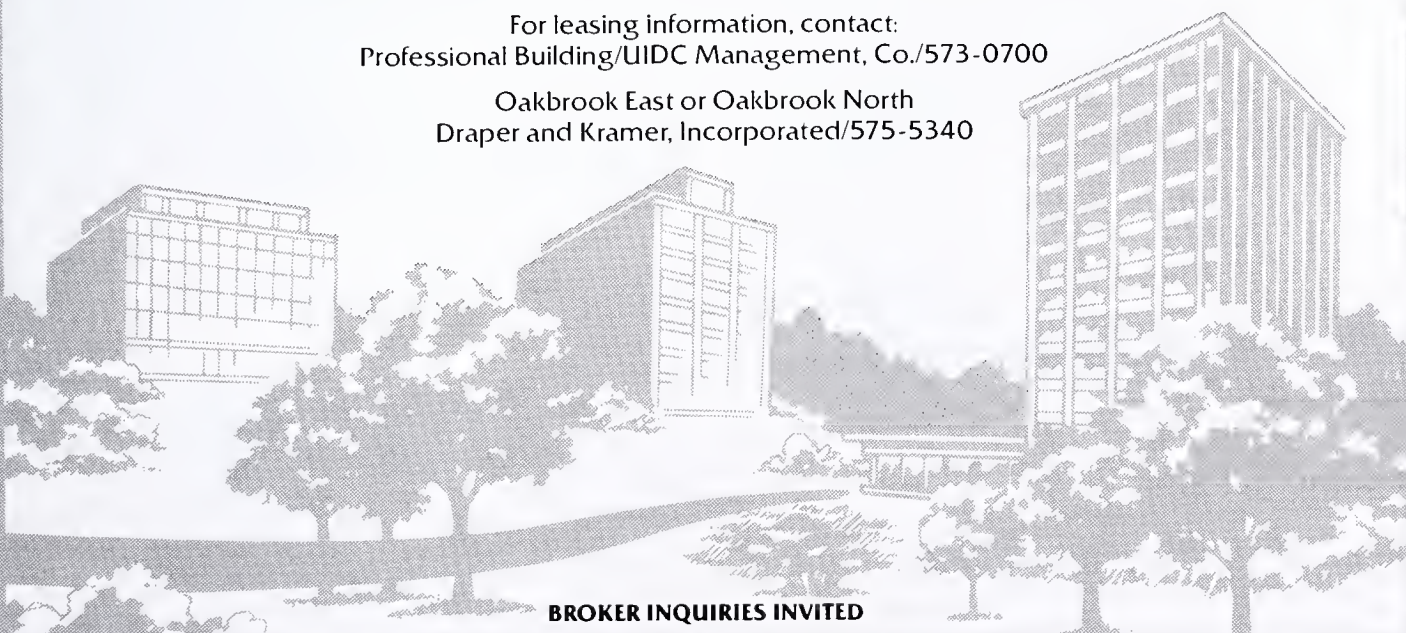
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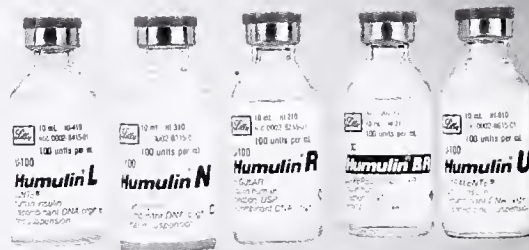
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AMA Report Focuses on Issues

Conflict of Interest

In April, 1987, the ISMS Board of Trustees directed that IMJ excerpt the 1986 AMA Council on Ethical and Judicial Affairs report titled above. The abbreviated material below covers only the Council's formal statements on the subject. The complete report, which includes appendices and illustrative data, may be obtained by contacting the American Medical Association.

Report A of the Council on Ethical and Judicial Affairs identifies situations which may give rise to conflicts of interest and provides recommendations for resolving them to the patient's benefit and in conformity with the Council's guidelines and public policy. These excerpts are reprinted with permission of the American Medical Association from the Proceedings of the House of Delegates, December 1986 Interim Meeting.

In 1984, the American Medical Association (AMA) House of Delegates adopted a series of statements on Conflict of Interest, which had been developed by the AMA Council on Ethical and Judicial Affairs. Those statements were:

Physician ownership interest in a commercial venture with the potential for abuse is not in itself unethical. Physicians are free to enter lawful contractual relationships, including the acquisition of ownership interests in health facilities or equipment or pharmaceuticals. However, the potential conflict of interest must be addressed by the following:

1. The physician has an affirmative ethical obligation to disclose to the patient or referring colleagues his or her ownership interest in the facility or therapy prior to utilization.

2. The physician may not exploit the patient in any way, as by inappropriate or unnecessary utilization.
3. The physician's activities must be in strict conformance with the law.
4. The patient should have free choice either to use the physician's proprietary facility or therapy or to seek the needed medical services elsewhere.
5. When a physician's commercial interest conflicts so greatly with the patient's interest as to be incompatible, the physician should make alternative arrangements for the care of the patient.

The Council promulgated these guidelines to supplement its opinion on Health Facility Ownership by Physician which provides:

A physician may own or have a financial interest in a for-profit

hospital, nursing home or other health facility, such as a free-standing surgical center or emergency clinic. However, the physician has an affirmative ethical obligation to disclose his ownership of a health facility to his patient, prior to admission or utilization.

Under no circumstances may the physician place his own financial interest above the welfare of his patients. The prime objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. For a physician to unnecessarily hospitalize a patient or prolong a patient's stay in the health facility for the physician's financial benefit would be unethical.

If a conflict develops between the physician's financial interest and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit. (Section 4.05, Current Opinions of the Council on Ethical and Judicial Affairs, 1986)

Acting at the direction of the AMA House of Delegates, the Council added specific recommendations to their guidelines. Their 1987 report was designed to, "identify situations that may give rise to conflicts of interest and provide suggestions for resolving them to

the patient's benefit in conformity with the Council's guidelines, and in conformity with relevant public policies. Examples of conflicts of interest between the physician and the patient are provided (a) in the absence of third parties, and (b) in the presence of third parties."

The Council, recommendations were as follows.

Situations with the Potential for Conflict of Interest

Example 1:

Physician dispenses drug or device to patient for profit.

Recommendation 1:

Although there are circumstances in which physicians may ethically engage in the dispensing of drugs, devices or other products, physicians are urged to avoid regular dispensing and retail sale of drugs, devices or other products when the needs of patients can be met adequately by local ethical pharmacies or suppliers.

Example 2:

Physician refers patient to a facility or service owned by the physician in whole or in part.

Recommendation 2:

In accordance with the Council's Conflict of Interest Guidelines, physicians may refer patients to facilities in which they have an ownership interest. However, physicians should seek to avoid even the appearance of impropriety in medical decisions that are even remotely related to their financial interests.

Example 3:

Physician pays or is paid by third party for referral of patients.

Recommendation 3:

Referrals should be based upon the referring physician's confidence in the competence and ability of the individual or health care facility's ability to perform the services needed by the

patient. When services are provided by more than one physician, each physician should submit his own bill and be compensated separately, if possible. If this is not possible and a fee for services personally rendered by more than one physician is to be divided, the nature of the financial arrangement should be made known to the patient. Payments to or by a physician for the referral of patients are improper. Mere referral does not constitute a professional service for which a fee may ethically be charged.

Example 4.

Physician's income is related to referral of patients to or from a third party.

Recommendation 4:

Where a physician's income may be enhanced by referrals to an entity in which he has an ownership interest, income generation should be separate from volume of referrals or utilization. Alternatives might include corporate structures where: (1) return on equity is a fixed or independently determined ratio reflecting capitalization rather than individual professional referrals; (2) management and professional entities are separate; and/or (3) there is independent utilization review, concurrently or retrospectively. Such mechanisms might help to assure (1) that income is not related to the number of referrals or the revenue generated by the physician owner or investor but, instead, to ownership and equity considerations; (2) that referrals are made for medically necessary services; and (3) that charges are not excessive.

Recommendation 5:

It is unethical to intentionally limit utilization of needed medical services to the detriment of a patient for the physician's own profit. If a third party limits a patient's access to necessary med-

ical services contrary to standard medical practice, the physician should so inform the patient and protest the limitation.

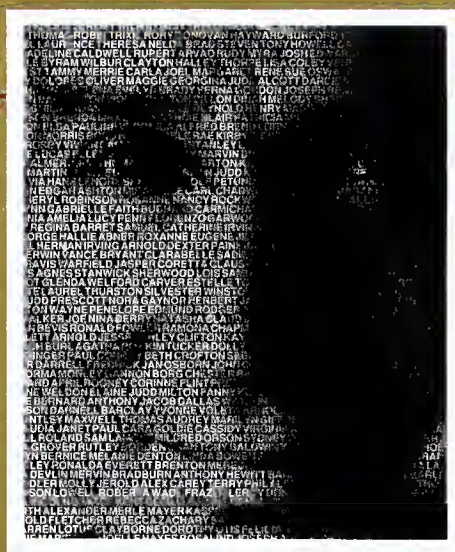
Conclusion

Financial rewards to physicians for the referral of patients or for failing to refer patients for necessary medical services can have, at least, the appearance of impropriety and can undermine the public's confidence in the medical profession. Medical decisions made solely on the basis of financially benefiting the physician are improper. The overriding principle is that conflicts between the physician's financial interest and the patient's medical interest must always be resolved to the benefit of the patient. Where the conflict is so great that the patient's interest is not served, the physician must cede the care of the patient to another qualified physician.

The trust and dependence reposed in the physician by the patient invokes an ethical obligation on the part of the physician far greater than that of the commercial purveyor of services. The obligation of the physician is to be an advocate for the patient. A physician must exercise medical judgment independently of his own or a third party's financial interests. No motive should be allowed to prevail against the physician's fundamental role of alleviating the suffering of his patients. If a third party attempts to corrupt the physician's exercise of medical judgment on behalf of his patients, the physician must be the advocate of the patient and vigorously oppose those who are adverse to the medical interests of the patient. If the physician's own interests are adverse to the patient's interests, alternative arrangements must be made for the care of the patient. The physician must never assume a position adverse to the interests of the patient. ◀

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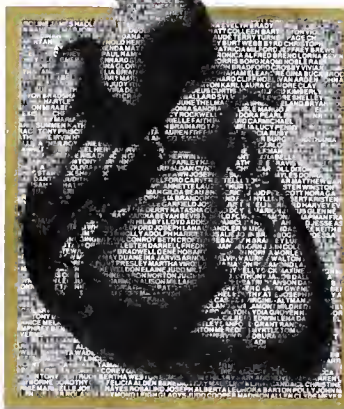
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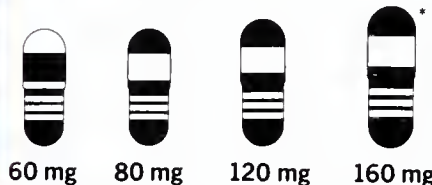
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 LIAN FLOYD ELLIOTT HAR
 MYRA JOSH EDWARD
 AMMY MERRIE CARLA JO
 LEY IRIS STEPHANIE CHA
 A JESSICA BERNARD MA
 BLAIR PATRICIA MIL
 ANNON MORRIS BOND
 AHAM ELEANORE GIN
 MORE CLAY PEARCE G
 NICOLE PETUNIA HA
 EEC CHERYL ROBINS
 VIN HUNTER NEVIN
 ATLAND COLEMAN
 ER PAINE JANE SH
 AWLEY KATHERINE
 EIRMA MYLES JULI
 NETTE LAUREL TH
 RANDALL PHYLLIS
 RION JULIUS GLENN
 JESSE ASHLEY CLIF
 ANCHE ROBIN JACO
 RK NOAH STEWART
 ORINNE FLINT PRESL
 RON NORTON JULIE
 SHIRLEY HARPER PE
 OLDIE CASSIDY VIRGI
 LYDIA GROVER RUTL
 SIBYL NOEL HUMPHR
 L BILL LILLIAN MARLE
 ADE FRAZER LEROY DO
 SMEREDITH ALEXAND
 ES MOND TONY HILARY
 ERTA LEONORA BART
 ENNIS CULLEN TABIT
 RENDAN GUNTHER E
 MARIO JAYNE MELIS
 SPER VITO NICHOLA
 Y JONATHAN SALLY
 ON SEAN WALDEN RO
 RT DIANE JENNIFER LE
 LLEEN DWIGHT MITCH
 INGRID CHANNING LIN
 ANSON ANDREW GALL
 ER ROXANNE ASHBY HAR
 A TRIXIE RORY BAYARD CH
 JOSEPH PAGE JULIE REX REY
 LEONA RUDY MARCUS SLOANE
 RA DONNA CRAIG ANNE ELMER
 HAM ADELINE HALLEY MILFORD DE
 ON PRISCILLA WILSON RUPERT HARR
 ATH STEVEN BRONSON JEAN PETER DIA
 NE LORNA ROBERTA NOBLE TOM SABIN
 T MIA BARTLETT BEAUDINAH JIM FRITZ D
 NE CECILIA TAMARA BEN ROSABELLE JU
 SLE SIMPSON BERNARD ERROL CORETTA
 VERETT MARGO LENA LORENZO CLIFF R
 N MARTIN THOMAS TONY COLEMAN LUCI
 DEN REBECCA COURTNEY NICOLE BREWS
 ER RHONDA TURNER MADELINE ELLEN MC
 OWLER JANET TONY THOMAS ROBERT SO
 T ROBIN HARDEN BRETT NEIL BORDEN OT
 T WATSON GEORGIA BARCLAY ODESSA
 ADWICK APRIL TODD ARDEN LAUR
 A MABEL SHERWIN PATIDA GINA
 ARD ARNOLD HILLIARD SILVES
 ORA DONAHUE EGAN MURRA
 DAMDEN EDNA MILES ALBER
 RUSSEL AUDREY ELI DEWE
 RNOLD TONY WILFRED CL
 DAM TYSON LARISSA A
 TON LIBBY OSCAR PHY
 OYD PHOEBE ARCH
 IS FRANKLIN LOT
 M RENEE CHA
 ANZELDA
 AS MEGA
 Y CRY
 SHEE

Feel like a MILLION



ONCE-DAILY
INDERAL[®] LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES 60, 80, 120, 160 mg

The one you know best
keeps looking better



BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL[®] LA brand of propranolol hydrochloride (Long Acting Capsules)

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. **Hypertension:** INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. **CARDIAC FAILURE:** Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. The abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing reverse T₃ and decreasing T₃.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be aware that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a rebound increase in intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease. Elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL (propranolol HCl) is administered. The catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncope, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbital, and rifampin accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and lidocaine have reduced clearance when used concomitantly with propranolol. Thyroxine may result in a lower than expected T₃ concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant reproductive toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animals at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised if INDERAL is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have usually required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasisiform rashes, dry eyes, male impotence, Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSEAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride sustained-release capsule for administration once daily. If patients are switched from Inderal Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for Inderal Tablets. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION — Dosage must be individualized. The usual initial dosage is 80 mg INDERAL once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS — Dosage must be individualized. Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal responses are obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE — Dosage must be individualized. The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS — 80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Reference:

1. Data on file, Ayerst Laboratories.

D7295/188

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AYERST**

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Effects of Implementation and Repeal **Mandatory CME**

Institutional sponsors of continuing medical education (CME) programs and a random sample of physicians in Illinois were surveyed concerning the effects of the implementation and subsequent repeal of mandatory CME legislation for physician relicensure in Illinois. This research was conducted by a committee of the Illinois Council on Continuing Medical Education early in 1985, after the repeal of the 1978 law. The new Medical Practice Act of 1987 does not require a physician to obtain a specific number of CME hours, nor to acquire a specific category of CME. However, it does require participation in CME activities as a condition for relicensure.

On January 1, 1978, legislation mandating continuing medical education (CME) for physician relicensure in Illinois was implemented by the State of Illinois. On January 1, 1984, the legislation was repealed. The implementation and subsequent repeal of mandatory CME provided an unprecedented opportunity to assess the need for laws mandating continuing education for physicians.

Consequently, all institutional sponsors of CME in Illinois and a random sample of Illinois physicians were surveyed as to their perceptions of the effects of the mandatory CME legislation in Illinois.

A survey questionnaire was sent to each of the 86 institutional sponsors of CME in Illinois accredited through the Illinois State Medical Society. Only institutional sponsors accredited as of 1984 (before the repeal of mandatory CME) were included in the survey. Responses were obtained from 80 of the 86 institutions (93%). A comparable

survey questionnaire was sent to a sample of 100 Illinois physicians randomly selected from Illinois State Medical Society members who had been in practice for at least one year prior to the implementation of mandatory CME. Questionnaires were returned by 76 physicians (76%).

Questionnaires to both groups asked respondents their perceptions of the effects of the implementation and repeal of mandatory CME on the following: (1) attendance at CME programs; (2) quality of health care rendered by physicians; (3) public image of physicians in Illinois; and (4) incidence of malpractice lawsuits.

The institutional sponsor questionnaire also asked respondents to report their perceptions of the effects of implementation and repeal of mandatory CME on: (1) the number of CME programs they sponsored; (2) the extent of financial and staff support for CME in their institution; and (3) planning of

CME programs within their institution.

Finally, both the sponsor and physician questionnaires asked respondents their positions on mandatory CME when it was still in effect, and if it were proposed again for Illinois relicensure.

Results

The accompanying tables reproduce the survey forms (absent essay sections) and tabulated results for the individual and institutional respondents. Physicians and institutions were largely in agreement in most instances; exceptions were perceptions regarding effect on attendance at CME programs, particularly those offering Category 1 credit. While institutions reported that implementation increased attendance and repeal decreased it, most physicians reported no change in their attendance habits.

Conclusion

Mandatory CME continues to be a highly controversial issue for both sponsors of continuing medical education and individual physicians who participate in CME learning activities. As this study has shown, many perceptions of the effects of mandatory CME and its subsequent revocation are partly dependent upon whether one's viewpoint is that of an institutional sponsor or a participant.

This is especially indicated in the study's finding that most sponsors

Institutional Survey Questionnaire on Mandatory CME

I. Number of Programs

1) In general, how was the number of CME programs sponsored by your institution affected by the implementation and subsequent repeal of mandatory CME in Illinois?	Greatly Increased	Moderately Increased	Stayed the Same	Moderately Decreased	Greatly Decreased
a) Implementation	13%	36%	51%		
b) Repeal		1%	74%	19%	5%
2) Specifically, how was the number of Category 1 CME programs sponsored by your institution affected by the implementation/repeal of mandatory CME in Illinois?	Greatly Increased	Moderately Increased	Stayed the Same	Moderately Decreased	Greatly Decreased
a) Implementation	21%	28%	50%	1%	
b) Repeal		1%	71%	18%	9%
3) In addition, how was the number of Category 2 CME programs sponsored by your institution affected by the implementation/repeal of mandatory CME in Illinois?	Greatly Increased	Moderately Increased	Stayed the Same	Moderately Decreased	Greatly Decreased
a) Implementation	4%	18%	72%	7%	
b) Repeal		8%	80%	8%	4%
4) Finally, how was the number of programs offered for neither Category 1 or 2 CME credit sponsored by your institution affected by the implementation/repeal of mandatory CME in Illinois?	Greatly Increased	Moderately Increased	Stayed the Same	Moderately Decreased	Greatly Decreased
a) Implementation	5%	6%	87%	1%	
b) Repeal			92%	6%	1%

II. Attendance

5) In general, how was overall attendance at CME programs at your institution affected by the implementation and subsequent repeal of mandatory CME in Illinois?	Greatly Increased	Moderately Increased	Stayed the Same	Moderately Decreased	Greatly Decreased
a) Implementation	17%	55%	27%	1%	
b) Repeal			31%	46%	23%
6) Specifically, how was attendance at Category 1 CME programs at your institution affected by the implementation/repeal of mandatory CME in Illinois?	Greatly Increased	Moderately Increased	Stayed the Same	Moderately Decreased	Greatly Decreased
a) Implementation	20%	49%	30%	1%	
b) Repeal			36%	43%	21%
7) In addition, how was attendance at Category 2 CME programs at your institution affected by the implementation/repeal of mandatory CME in Illinois?	Greatly Increased	Moderately Increased	Stayed the Same	Moderately Decreased	Greatly Decreased
a) Implementation	1%	28%	68%	3%	
b) Repeal			74%	21%	5%
8) Finally, how was attendance or participation at programs offered for neither Category 1 or 2 CME credit at your institution affected by the implementation/repeal of mandatory CME in Illinois?	Greatly Increased	Moderately Increased	Stayed the Same	Moderately Decreased	Greatly Decreased
a) Implementation	3%	16%	81%		
b) Repeal			80%	19%	1%
9) Does your organization require periodic attendance or participation by physician members in educational programs or activities?					
	Yes 39%	No 61%			

(Continued on following page)

felt mandatory CME "greatly increased" or "moderately increased" overall attendance at CME programs, while the repeal of mandatory CME "moderately decreased" or "greatly decreased" attendance. Conversely, the majority of physicians responding stated that their overall attendance "stayed the same" whether CME

was mandated or repealed.

The use of mandated learning for professional accountability will, no doubt, continue to be a hotly debated issue, especially in the field of medicine, where nearly half the states use this criterion for purposes of relicensure. In Illinois, the advent of a new mandatory CME law will provide additional opportu-

nity for research in this area when the requirements of the law become effective in 1990.

Acknowledgement

The ISMS wishes to thank Charles E. Osborne, Ed.D. and Jerry Colliver Ph.D. of Southern Illinois University School of Medicine for their special contributions to the design, implementation and analysis of this research study.

Institutional Survey Questionnaire on Mandatory CME—Cont'd

III. Quality of Care

- 10) Considering your administrative experience in CME, what effect did the implementation and subsequent repeal of mandatory CME in Illinois have on the quality of care rendered by physicians in Illinois?
- | | Greatly
Beneficial
Effect | Moderately
Beneficial
Effect | No
Effect | Moderately
Detrimental
Effect | Greatly
Detrimental
Effect |
|-------------------|---------------------------------|------------------------------------|--------------|-------------------------------------|----------------------------------|
| a) Implementation | 1% | 37% | 60% | 1% | |
| b) Repeal | | | 82% | 16% | 1% |
- 11) Considering your administrative experience in CME, what effect did the implementation/repeal of mandatory CME in Illinois have on the *general overall* quality of health care in Illinois?
- | | Greatly
Beneficial
Effect | Moderately
Beneficial
Effect | No
Effect | Moderately
Detrimental
Effect | Greatly
Detrimental
Effect |
|-------------------|---------------------------------|------------------------------------|--------------|-------------------------------------|----------------------------------|
| a) Implementation | 3% | 35% | 60% | 2% | |
| b) Repeal | | 3% | 75% | 20% | 1% |

IV. Public Image and Malpractice

- 12) Considering your administrative experience in CME, what is your perception of the effect of the implementation and subsequent repeal of mandatory CME in Illinois on the public image of physicians in Illinois?
- | | Greatly
Beneficial
Effect | Moderately
Beneficial
Effect | No
Effect | Moderately
Detrimental
Effect | Greatly
Detrimental
Effect |
|-------------------|---------------------------------|------------------------------------|--------------|-------------------------------------|----------------------------------|
| a) Implementation | 4% | 29% | 66% | 1% | |
| b) Repeal | | 1% | 76% | 18% | 4% |
- 13) Considering your administrative experience in CME, what is your perception of the effect of the implementation/repeal of mandatory CME in Illinois on the incidence of malpractice law suits in Illinois?
- | | Greatly
Increased | Moderately
Increased | Stayed
the Same | Moderately
Decreased | Greatly
Decreased |
|-------------------|----------------------|-------------------------|--------------------|-------------------------|----------------------|
| a) Implementation | | 3% | 84% | 13% | |
| b) Repeal | | 16% | 81% | 2% | 2% |

V. Financial and Staff Support

- 14) What was the effect of the implementation and subsequent repeal of CME on the level of financial support for CME in your institution?
- | | Greatly
Increased | Moderately
Increased | Stayed
the Same | Moderately
Decreased | Greatly
Decreased |
|-------------------|----------------------|-------------------------|--------------------|-------------------------|----------------------|
| a) Implementation | 12% | 26% | 61% | 1% | |
| b) Repeal | | 1% | 83% | 8% | 8% |
- 15) Your budget may have been fixed for the year prior to the repeal of mandatory CME. What effect do you anticipate for future financial support of CME at your institution?
- | | Greatly
Increase | Moderately
Increase | Stay
the Same | Moderately
Decrease | Greatly
Decrease |
|--|---------------------|------------------------|------------------|------------------------|---------------------|
| | | 3% | 78% | 15% | 4% |
- 17) Were any of the above positions created as a result of the implementation of mandatory CME?
- | | |
|---------|--------|
| Yes 18% | No 82% |
|---------|--------|
- 18) Based on the repeal of mandatory CME have you experienced or do you anticipate any future changes in the number of CME support staff?
- | | |
|---------|--------|
| Yes 12% | No 88% |
|---------|--------|

VI. CME Planning

- 19) Did your methods for assessing needs change due to the implementation and subsequent repeal of mandatory CME?
- | | | |
|-------------------|---------|--------|
| a) Implementation | Yes 24% | No 76% |
| b) Repeal | Yes 7% | No 93% |
- 20) Did your teaching methods for your programs change due to the implementation/repeal of mandatory CME?
- | | | |
|-------------------|---------|--------|
| a) Implementation | Yes 12% | No 88% |
| b) Repeal | Yes 6% | No 94% |
- 21) Did your evaluation procedures change due to the implementation/repeal of mandatory CME?
- | | | |
|-------------------|---------|--------|
| a) Implementation | Yes 25% | No 75% |
| b) Repeal | Yes 9% | No 91% |
- 22) How has your reliance on speakers provided by pharmaceutical companies been affected by the implementation/repeal of mandatory CME?
- | | Greatly
Increased | Moderately
Increased | Stayed
the Same | Moderately
Decreased | Greatly
Decreased |
|-------------------|----------------------|-------------------------|--------------------|-------------------------|----------------------|
| a) Implementation | 7% | 11% | 80% | 1% | 1% |
| b) Repeal | 4% | 4% | 83% | 8% | 1% |

VII. Your Position

- 23) Which of the following best describes your position on mandatory CME *when it was still in effect* in Illinois:
- | | Strongly Supported | Supported | No Position | Opposed | Strongly Opposed |
|--|--------------------|-----------|-------------|---------|------------------|
| | 21% | 44% | 14% | 19% | 3% |
- 24) Which of the following best describes your position on the repeal of mandatory CME in Illinois?
- | | Strongly Supported | Supported | No Position | Opposed | Strongly Opposed |
|--|--------------------|-----------|-------------|---------|------------------|
| | 10% | 23% | 28% | 29% | 9% |
- 25) Which of the following best describes your position on mandatory CME *if it were proposed again* for Illinois relicensure:
- | | Strongly Support | Support | No Position | Oppose | Strongly Oppose |
|--|------------------|---------|-------------|--------|-----------------|
| | 24% | 26% | 21% | 18% | 11% |

(continued)

Physician Survey Questionnaire on Mandatory CME

I. Attendance

- 1) In general, how was your *overall* attendance at CME programs affected by the implementation and subsequent repeal of mandatory CME in Illinois?
- | | Greatly
Increased | Moderately
Increased | Stayed
the Same | Moderately
Decreased | Greatly
Decreased |
|-------------------|------------------------------|---------------------------------|----------------------------|---------------------------------|------------------------------|
| a) Implementation | 4% | 24% | 72% | 0% | |
| b) Repeal | 0% | 5% | 81% | 14% | |
- 2) Specifically, how was your attendance at *Category 1* CME programs affected by the implementation/repeal of mandatory CME in Illinois?
- | | Greatly
Increased | Moderately
Increased | Stayed
the Same | Moderately
Decreased | Greatly
Decreased |
|-------------------|------------------------------|---------------------------------|----------------------------|---------------------------------|------------------------------|
| a) Implementation | 4% | 27% | 68% | | |
| b) Repeal | | 5% | 75% | 19% | |
- 3) In addition, how was your attendance at *Category 2* CME programs affected by the implementation/repeal of mandatory CME in Illinois?
- | | Greatly
Increased | Moderately
Increased | Stayed
the Same | Moderately
Decreased | Greatly
Decreased |
|-------------------|------------------------------|---------------------------------|----------------------------|---------------------------------|------------------------------|
| a) Implementation | | 18% | 82% | | |
| b) Repeal | | 3% | 88% | 9% | |
- 4) Finally, how was your attendance or participation at programs offered for *neither* Category 1 or 2 CME credit affected by the implementation/repeal of mandatory CME in Illinois?
- | | Greatly
Increased | Moderately
Increased | Stayed
the Same | Moderately
Decreased | Greatly
Decreased |
|-------------------|------------------------------|---------------------------------|----------------------------|---------------------------------|------------------------------|
| a) Implementation | | 8% | 92% | | |
| b) Repeal | | 1% | 95% | 4% | |
- 5) Does any organization or association to which you belong require periodic attendance or participation in educational programs or activities?
- Yes 47% No 53%**

II. Quality of Care

- 6) What effect did the implementation/repeal of mandatory CME in Illinois have on the quality of care you render to your patients?
- | | Greatly
Beneficial
Effect | Moderately
Beneficial
Effect | No
Effect | Moderately
Detrimental
Effect | Greatly
Detrimental
Effect |
|-------------------|--|---|----------------------|--|---|
| a) Implementation | 1% | 18% | 79% | 1% | |
| b) Repeal | | 7% | 90% | 3% | |
- 7) In your opinion, what effect did the implementation/repeal of mandatory CME in Illinois have on the quality of care rendered by *physicians* in Illinois?
- | | Greatly
Beneficial
Effect | Moderately
Beneficial
Effect | No
Effect | Moderately
Detrimental
Effect | Greatly
Detrimental
Effect |
|-------------------|--|---|----------------------|--|---|
| a) Implementation | | 41% | 59% | | |
| b) Repeal | | 6% | 71% | 23% | |
- 8) In your opinion, what effect did the implementation/repeal of mandatory CME in Illinois have on the *general* overall quality of health care in Illinois?
- | | Greatly
Beneficial
Effect | Moderately
Beneficial
Effect | No
Effect | Moderately
Detrimental
Effect | Greatly
Detrimental
Effect |
|-------------------|--|---|----------------------|--|---|
| a) Implementation | | 37% | 63% | | |
| b) Repeal | | 6% | 74% | 20% | |

III. Public Image and Malpractice

- 9) What is your perception of the effect of the implementation/repeal of mandatory CME in Illinois on the public image of physicians in Illinois?
- | | Greatly
Enhanced | Moderately
Enhanced | No Effect | Moderately
Detracted
From | Greatly
Detracted
From |
|-------------------|-----------------------------|--------------------------------|------------------|--|---------------------------------------|
| a) Implementation | 3% | 34% | 60% | 3% | |
| b) Repeal | | 6% | 76% | 17% | 1% |
- 10) What is your perception of the effect of the implementation/repeal of mandatory CME in Illinois on the incidence of malpractice law suits in Illinois?
- | | Greatly
Increased | Moderately
Increased | Stayed
the Same | Moderately
Decreased | Greatly
Decreased |
|-------------------|------------------------------|---------------------------------|----------------------------|---------------------------------|------------------------------|
| a) Implementation | 1% | 1% | 90% | 7% | |
| b) Repeal | | 10% | 90% | | |

IV. Your Position

- 11) Which of the following best describes your position on mandatory CME *when it was still in effect* in Illinois:
- | | Strongly Supported | Supported | No Position | Opposed | Strongly Opposed |
|--|---------------------------|------------------|--------------------|----------------|-------------------------|
| | 8% | 42% | 9% | 26% | 15% |
- 12) Which of the following best describes your position on Mandatory CME *if it were proposed again* for Illinois relicensure:
- | | Strongly Support | Support | No Position | Oppose | Strongly Oppose |
|--|-------------------------|----------------|--------------------|---------------|------------------------|
| | 8% | 36% | 8% | 23% | 24% |

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Illinois Society of Medical Assistants

Meet the Candidates

BY LUCILLE PERCE, CMA-C

The 1988-89 election of ISMA officers will take place Friday, April 29, 1988 at the Westin O'Hare Hotel in Rosemont, Illinois. The following candidates have been nominated for office on the executive board:

■ Robin Bluestein, CMA-C (Northwest Cook Chapter), will assume the office of president Saturday, April 30, at the installation banquet. Robin, named president-elect last year, received her certification in 1980 and was revalidated in 1985. Locally, Robin has served as corresponding secretary, recording secretary, vice president, president-elect, president and immediate past president. She co-chaired the long-range planning committee, symposium, and public relations committee, and has served as both alternate delegate and delegate to the AAMA National Convention.

■ Karen Coughlin, CMA (McLean Chapter), is the candidate for 1st vice president. Karen received certification in 1984. On the local level, she has served as vice president, president-elect and president; she is currently immediate past president. She has served on the ways and means committee, bylaws committee, education committee, and the long-range planning committee and has chaired the resolutions committee.

■ Lesa Hildebrand, Ed. M., CMA-C (West Cook Chapter), is running for 2nd Vice President. Lesa received certification in 1979 and was revalidated in 1985. On the local level, she has served as councilor, public relations chairman, education chairman and president. On the state level Lesa was public relations chairman and 2nd vice president from 1984-85. She is coordinator of the medical assisting program at Triton College in River

Grove, Illinois.

■ Marjorie Goldasich (LaSalle Chapter), hopes to remain recording secretary, a position she has held for the past two years. On the local level, she has served as program chairman, membership secretary, councilor and was president a dozen times since 1969.

■ Rose Hall, RN, CMA-C (St. Clair Chapter), is the membership secretary candidate. Rose received certification in 1972, has recertified once and plans to recertify again in the near future. On the local level, she has served as health careers and continuing education chairman and councilor. On the state level, Rose has served as in-service education chairman. Since 1978, Rose has been a member of the accreditation survey team for Accreditation of Medical Assistant programs at post-secondary institutions. She has attended many AAMA National Conventions and was a delegate in 1987. Rose has been the coordinator and instructor of the medical assisting program at Belleville Area College since 1971.

■ Linda Harp, CMA (St. Clair Chapter), is running for the office of treasurer. She received certification in 1978. On the local level, Linda has served as historian, recording secretary, president-elect and president. On the state level, Linda has served as historian, and ways & means chairman. She has been a member of the long-range planning committee and has been the membership secretary for the past two years.

■ Mary Frances Burton (Chicago Chapter), is candidate for speaker of the house. On the local level, Mary Frances has served as recording secretary, corresponding secretary, vice president, president and

immediate past president. Also, on the local level, Mary Frances has been chairman of the board of trustees and the ways & means committee. On the state level, Mary Frances has served as bylaws chairman, legislation chairman and has been a member of the finance committee, the minutes editing committee and the resolutions committee. Mary Frances was the membership secretary for two years and has been the treasurer for three. Additionally, Mary Frances was a member of the international relations committee for two years.

■ Roxanne Steffens, CMA (Rock Island Chapter), is vice speaker of the house candidate. She received certification in 1982 and recertified in 1987. On the local level, Roxanne has served as president for two terms, has been on the membership committee, ways & means committee, bylaws committee and was co-chairman to the state convention in 1982. On the state level, Roxanne has been the bylaws committee chairman for three years. She established a clinical procedures program for medical assistants at her local college.

The Illinois Society of Medical Assistants 1988 Convention will be held April 29-May 1, 1988, at the Westin O'Hare Hotel in Rosemont, Illinois.

For further information regarding ISMA and/or medical assisting, please contact Cheryl Hutchison, CMA, ISMA president, 53 Lockhaven, Granite City 62040; or the public relations co-chairpersons: Lesa B. Hildebrand, Ed. M., CMA-C, Triton College, 2000 Fifth Avenue, River Grove 60171; or Lucille Perce, CMA-C, 22W384 Teakwood, Glen Ellyn 60137. ◀

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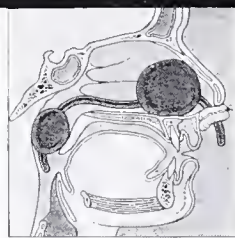
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| Significance of Elevated Erythrocyte Sedimentation Rates | Psychiatric Reactions Caused by Lidocaine Toxicity |
| Glucose Tolerance and Pregnancy Complications Among Nondiabetic Women | |

CUMULATIVE INDEX

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 782-1654.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or

sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

May

Allergy

Resident Fellow Program

For: Interested physicians. Lecture, May 16, Holiday Inn, Chicago City Centre. **Sponsor:** Illinois Society of Allergy and Clinical Immunology, 800 E. Northwest Hwy., Suite 1080, Palatine, IL 60067. **Fee:** \$20 (dinner). **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** Diane Kubis. **Phone:** (312) 359-3090.

Echocardiography

Echocardiography

For: Interested physicians. Lecture, May 24, DeKalb, IL. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, Ext. 3484.

Emergency Medicine

1988 Illinois Combined Scientific Assembly

For: Emergency room physicians and other health professionals. Annual meeting, May 26-28, The Hamilton Hotel, Itasca, IL. **Sponsor:** Illinois Chapter of the American College of Emergency Physicians, 1645 Des Plaines Avenue, Des Plaines, IL 60018. **Fee:** \$105-225. **Reg. Limit:** None. **Credit:** Category 1: 16 hours. **Contact:** Jeannine Helms. **Phone:** (312) 298-1970.

Family Medicine

Treatment Decisions in AIDS

For: Family practitioners and internists. Symposium, May 19-21, Chicago, IL. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** \$150. **Reg. Limit:** 500. **Credit:** Category 1: 18 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Infectious Disease

Viral Hepatitis—Type B

For: Interested physicians. Lecture, May 3, DeKalb, IL. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour; AAFP Prescribed: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, Ext. 3484.

Internal Medicine

Diabetic Neuropathy

For: Interested physicians. Lecture, May 31, DeKalb, IL. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, Ext. 3484.

Obstetricians/Family Practice

Teratology Conference: The Patient at Risk for Birth Defects—Physician Responsibility and Liability

For: Interested physicians. Conference, May 7, Illinois Masonic Medical Center, Chicago, IL. **Sponsor:** Illinois Masonic Medical Center, Reproductive and Medical Genetics Section, Department of OB/Gyn, 836 W. Wellington, Chicago, IL 60657. **Fee:** \$100. **Reg. Limit:** 150. **Credit:** Category 1: 8 hours. **Contact:** Janet Dalzell. **Phone:** (312) 883-7045.

Pathology

Pathology of the Neuroendocrine System

For: Pathologists. Slide seminar and annual dinner, May 9, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644 and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours for Chicago Pathology Society members only. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

Psychiatry

The Psychiatric Interview

For: Psychiatrists. Course, May 13-15, Chicago. **Sponsor:** University of Chicago, Office of CME, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** \$375. **Reg. Limit:** 150. **Credit:** Category 1: 18 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Substance Abuse

Physician's Role in Recognizing Substance Abuse

For: Interested physicians. Lecture, May 5, Fishers Restaurant, Belleville, IL. **Sponsors:** St. Clair County Medical Society and Illinois State Medical Society. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1.5 hours. **Contact:** Adrienne Noubertian. **Phone:** (618) 397-7633.

Physician's Role in Recognizing Substance Abuse/Pediatric Substance Abuse/Diagnosis and Treatment of Cocaine Abuse

For: Interested physicians. Lecture, May 25, St. Therese Medical Center, 2615 W. Washington, Waukegan, Illinois 60085. **Sponsors:** St. Therese Medical Center and Illinois State Medical Society. **Reg. Limit:** None. **Credit:** Category 1: 3 hours. **Contact:** Marion Henderson. **Phone:** (312) 360-2702.

Surgery

Low Back Pain

For: Interested physicians. Lecture, May, 17, DeKalb, IL. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour; AAFP Prescribed: 1 hour. **Contact:** K. Reddy, M.D. **Phone:** (815) 756-1521, Ext. 3484.

June

Obstetrics/Gynecology

Obstetrics and Gynecology Review Course

For: OB/GYN's. Course, June 13-18, Chicago. **Sponsor:** University of Chicago, Center for Continuing Medical Education, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** \$550. **Reg. Limit:** 300. **Credit:** Category 1: 39 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Ophthalmology

Corneal Surgery for the Anterior Segment Surgeon: Hands-On Workshop

For: Ophthalmologists. Workshop, June 24-25, Chicago. **Sponsor:** The Cornea Service, Dept. of Ophthalmology, Rush-Presbyterian-St. Luke's Medical Center, 1753 W. Congress Parkway, Chicago, IL 60612. **Fee:** \$300. **Reg. Limit:** 100. **Credit:** Category 1: 16 hours. **Contact:** Victoria O'Sullivan, University Office of CME, 600 S. Paulina, Chicago, IL 60612. **Phone:** (312) 942-7119.

Contact Lens Course

For: Ophthalmologists. Course, June 17-18, University of Illinois Hospital, Eye & Ear Infirmary, Chicago. **Sponsor:** University of Illinois College of Medicine, Dept. of Ophthalmology, 912 S. Wood, Chicago, IL 60612. **Fee:** \$150. **Reg. Limit:** 200. **Credit:** Category 1: pending. **Contact:** Conference Registrar. **Phone:** (312) 996-5225.

Otolaryngology

Endoscopic Sinus Surgery Workshop

For: Otolaryngologists. Workshop, June 17-18, Chicago. **Sponsor:** University of Chicago School of Medicine, Office of Continuing Medical Education, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** 60. **Credit:** Category 1: To be determined. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Pathology

Seminar on New Technology

For: Pathologists. Lecture, June 13, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644 and Michael Reese Hospital and Medical Center. **Fee:** None. **Credit:** Category 1: 2 hours for Chicago Pathology Society members only. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

July

Allergy

Clinical Allergy for the Practicing Physician

For: Physicians. Seminar, July 21-23, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** \$175. **Reg. Limit:** 150. **Credit:** Category 1: 15 hours; AAFP Prescribed: 15 hours; and ADA: 15 hours. **Contact:** Loretta Giacoletto. **Phone:** (800) 325-9862.

"I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state.

The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 1440 W. Washington Blvd., Chicago 60607. Telephone (312) 243-2000.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

In addition, the American Cancer Society provides Fresh Start clinic training anywhere in Illinois for hospitals and industries. Educational materials, pamphlets, posters, films and training can also be obtained at no charge. For information, contact your local ACS office, or the Illinois Division, Inc., at 37 South Wabash Ave., Chicago 60603; (312) 372-0471.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

May 2	Illinois Masonic Medical Center	Chicago
May 3	Rush North Shore Medical Center	Skokie
May 9	Northwestern Memorial Hospital	Chicago
May 19	Carle Clinic	Urbana
May 23	Grant Hospital Wellness Center	Chicago
June 6	Weiss Memorial Hospital	Chicago
June 6	Rush North Shore Medical Center	Skokie
June 14	Carle Clinic	Urbana
June 15	St. Therese Medical Center	Waukegan

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July 6-8, 1988

Fiberoptic Esophagogastric Endoscopy

July 11-13, 1988

Specialty Review in Pediatrics

July 18-24, 1988

Specialty Review in Emergency Medicine

July 25-30, 1988

Specialty Review in Internal Medicine

July 31-August 6, 1988

Specialty Review in Surgical Critical Care Medicine

August 15-19, 1988

Gynecologic Surgical Techniques

August 25-27, 1988

Specialty Review in General Surgery, Part I

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Abstracts of Board Actions

Continued from page 228

Physicians should report to marriage license applicants who are subjects of an HIV antibody test, only negative ELISA results, or positive results of a Western blot or other confirmatory test. Positive ELISA results which have not been confirmed should not be reported to patients, since non-confirmed results could confuse and cause unnecessary concern by patients.

■ Disclosure of a Patient's HIV Antibody Status

ISMS supports the sharing of information about the HIV antibody status of a patient with those physicians and health personnel who have a need to know such information due to their involvement in the patient's care. Such personnel must recognize their responsibility to maintain information in compliance with state law governing the confidentiality of this and other patient information.

COMMITTEE ON DRUGS AND THERAPEUTICS

The Board approved the following drug products for inclusion in the IDPA Drug Manual: Cipro (ciprofloxacin HCl); Hytrin (Terazosin HCl); Normozide (Labetalol HCl); Resol (Oral Electrolyte Rehydration Solution).

The Board also recommended that the following drugs not be included in the IDPA Drug Manual: Esigic with Codeine (Butalbital); Elocon (Mometasone Furoate Ointment 0.1%); Mevacor (Lovastatin); Aero-chamber and Attends Wash Cloth.

The Board further recommended that IDPA include Buspar in its Drug Manual, extend coverage of Lopid to GA and AMI recipient categories and continue to not include Urocit-K in the Drug Manual.

In addition, the Board recommended that the drug product Lytrin be deleted from the Drug Manual.

OTHER ACTIONS

- In addressing various other issues, the Board:
- Authorized introduction of a Memorial Resolution for Dr. Goslin introduced by Edward J. Fesco, M.D., President.
- Accepted the September 30, 1987, Financial Statements; December 31, 1987, IMPAC Collection Data; December 31, 1987, Dues Payment Report, and approved Requests for Changes in Membership Status.
- Discussed various issues regarding distribution of IMPAC funds.
- Ratified a letter to be sent to the Crescent Counties Foundation for Medical Care responding to their requests that ISMS: (1) Comment upon review criteria; and (2) Consider publishing or reviewing the "Quality Assurance Bulletin" which is developed by the Foundation. The letter is to state that: (1) While there is no official ISMS position, informal review of PRO guidelines can be accomplished

by members of the Third Party Payment Processes Committee and Council on Economics; and (2) ISMS does not feel it necessary to reprint the "Quality Assurance Bulletin" at this time.

- Agreed to urge IDPA to eliminate the current Medichex "Healthy Kids" claim form DPA PH0600 and utilize the regular MMIS IDPA claim form for these services.
- Agreed to advise the appropriate governmental entities of the Society's opposition, in its proposed form, to the development of the "Proposal for an Ambulatory Care System in Chicago and Cook County." This proposal would affect both Public Aid recipients and the uninsured indigent who reside in Cook County.
- Approved an Unfinished Business Report on Resolution 49 (A-87), entitled "Anti-Physician Letters" for transmittal to the 1988 House of Delegates.
- Adopted a revised position paper titled, "Physician Interrelationships with Non-Physician Health Care Professionals."
- Agreed to delete positions titled: (1) Joint Practice (BOT: 6/80); (2) Physician Extenders (BOT: 8/77); and (3) Physician Extenders (BOT: 11/79).
- Approved development of a proposal for a "Physician Placement Information Clearinghouse," including the financial requirements of such a clearinghouse, for presentation at the April Board meeting.
- Agreed that: (1) Legislation be introduced that would protect physicians more fully under the Illinois Physician's Lien mechanism as directed by Res. 1 (A-87); and (2) The Illinois Workers' Compensation Act be amended as directed by Res. 32 (A-87). This would make services rendered in Worker's Compensation cases subject to the provisions of the Physicians Lien Act.
- Agreed to ask the IDPH to amend the regulations under the Hospital Licensing Act to clarify that residents may prescribe orders for medication and treatment, provided they do so in conformance within the limitations of their specific residency training.
- Approved for introduction in the Illinois General Assembly legislation to be drafted by legal counsel, exempting physician retirement plans from bankruptcy proceedings.
- Approved an Unfinished Business Report on Resolution 36 (A-87), entitled "Medical Studies Act" for transmittal to the 1988 House of Delegates.
- Approved the introduction of legislation requiring employers to offer employees the choice between private insurance and an HMO.
- Approved the publication of the revised booklet titled, "A Physician's Guide to the Illinois Living Will Act."

- Approved the publication of the revised "Guidelines for Writing Do Not Resuscitate Orders."
- Approved the position statements, "Peer Review of Workers Compensation Services" and "Educating Physicians about Injured Workers," in lieu of position statement, "Workmen's Compensation." (BOT: 9/81)
- Approved the position statement, "Return of Injured Workers to the Workplace."
- Approved submitting a resolution to adopt policy statement on the Radiological Exams of Injured Workers, in lieu of HOD (A-82) policy entitled "Workers Compensation."
- Approved resolution for submission to the HOD to delete policy statement titled "Disaster Teams."
- Referred back to the Council on Medical Services a recommendation that a letter be sent to the IHSA urging that organization to require shin guards for high school soccer players.
- Agreed to submit four resolutions to the ISMS 1988 House of Delegates deleting policy statements titled, "Inadequate HMO Psychiatric Benefits," "Hospital Procedures with Mental and Physical Illness," "Involuntary Certification" and "Minimum Standards for Health Insurance Policies."
- Agreed to investigate low-cost, family-oriented trips specifically geared for young physicians and ideally coupled with continuing medical education.
- Agreed to pursue development of a Young Physician Resource Directory.
- Agreed with the recommendation of the Council on Public Relations and Membership Services that there is no overriding need to change ISMS council and committee meetings. This issue was studied by the Council as a result of a 1987 ISMS Annual Meeting House resolution on investigating new ways to conduct meetings.
- Agreed to endorse in concept the "Beautiful Babies" campaign. Formal endorsement will be made only after various questions and concerns are resolved. The campaign is being sponsored by WBBM Television and the University of Chicago Hospital to encourage prospective mothers to obtain prenatal care.
- Approved revised Guidelines for Accreditation Decisions.
- Agreed to delete the position statement titled "Resurveys" (BOT: 1/83) from the ISMS Official Actions.
- Approved ISMS participation in the March meeting of the Chicago Lung Association aimed at improving the care and treatment options of ventilator assisted patients. The Board voiced no objection to Dr. Joel Press, the Resident Section Representative to the Council on Medical Services, attending the March meeting on behalf of ISMS.

PROGRAMS

The Board agreed to investigate co-sponsoring, with the medical student and/or resident physician sections, workshops on the residency selection process to be

patterned after a highly successful seminar conducted by the medical student section in November 1987.

NOMINATIONS

Various nominations and appointments were approved or ratified by the Board as follows:

- Ratified the nominations of: (1) Dr. James L. McGee, Decatur, to serve on the IDPH Medical and Basic Science Group for Data-Based Intervention for Cancer Control in Illinois; and (2) Drs. John Barton, Chicago; Ira Chasnoff, Chicago; Donald Graham, Springfield; Donald Matthieu, Jr., Decatur; Richard Sasseti, Chicago; and Larry Von Behren, Springfield, to serve on Illinois AIDS Advisory Council.
- Agreed to submit the following nominations: (1) Dr. Stanley Zydlo, Jr., Palatine, to serve on IDPH State Emergency Medical Service Disciplinary Board; and (2) Dr. H. Gary Gardner, Darien, to serve on an Illinois Department of Transportation committee encouraging the utilization of seat belts.
- Agreed to award the five 1987-88 Team Physician Awards to Drs. Albert Cunningham, Normal; Russell Gibson, LaGrange; James Green, Jacksonville; Paul Jorden, Carol Stream, and Thomas Regan, Palos Heights.
- Agreed to the selection of Dr. Luke Burchard as the physician nominee and The Care Center of Springfield, Illinois, as the nonphysician nominee, to receive the 1988 Public Service Awards at the 1988 Annual Meeting of the House of Delegates.
- Authorized the chairmen of the ISMS Board of Trustees and AMA Delegation to write a letter, if deemed appropriate, to the AMA Board endorsing the nomination of Mr. K. Gregory Lucchesi to serve as the Student member on the AMA Council on Legislation.

PLI III STRATEGY AND 1988 LEGISLATIVE RACES

The Board reviewed an informational report on the proposed PLI III and the 1988 legislative races. The Board agreed that there will continue to be strong efforts to achieve further tort reform, with particular emphasis on limiting awards for noneconomic damages. The Board will review the legislative races again following the March 15th primary.

INFORMATIONAL REPORTS

Informational reports were presented by the Policy Committee, ISMIS, ISMIE, Resident Physicians Section, Auxiliary, IMPAC, Trustees, Hospital Medical Staff Section, Speaker and AMA Delegation Chairman.

NEXT MEETING

The next Board meeting was set for April 21, 1988, at the Westin O'Hare Hotel, Rosemont. ◀

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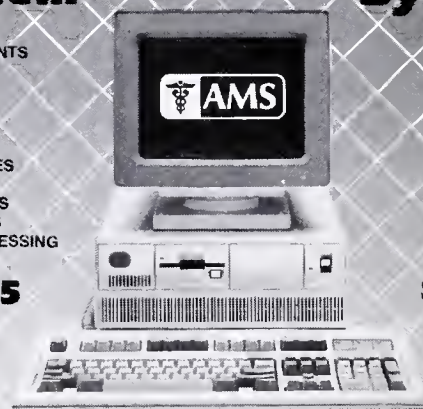
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VOL 5 NO 1 • JANUARY 1988

Effect of Medical versus Surgical Therapy for Coronary Disease / PETER PEDUZZI, PhD, et al.

Electrophysiological Testing and Nonsustained Ventricular Tachycardia / PETER R. KOWFY, MD, et al.

Residual Coronary Artery Stenosis after Thrombolytic Therapy / LOWELL E. SATLER, MD, et al.

Assessment of Aortic Regurgitation by Doppler Ultrasound / PAUL A. GRAYBURN, MD, et al.

Emboic Risk Due to Left Ventricular Thrombi / JOHN R. STRATTON, MD

Hemodynamic Effects of Diltiazem in Chronic Heart Failure / DANIEL L. KULICK, MD, et al.

Cardiovascular Reserve in Idiopathic Dilated Cardiomyopathy / RICKY D. LATHAM, MD, et al.

Overview • Coronary Angioplasty: Evolving Applications / GEORGE W. VETROVEC, MD

* Journals reviewed include: *Circulation*, *American Heart Journal*, *Journal of the American College of Cardiology*, *British Heart Journal*, *Chest*, *The American Journal of Cardiology*, *The New England Journal of Medicine*, *Annals of Internal Medicine*, *American Journal of Medicine*, and *The Journal of the American Medical Association*.

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IMJ

Illinois Medical Journal

Official Journal of the Illinois State Medical Society

Volume 173, Number 5, May 1988

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Beyond the Bottom Line



As physicians, we know that isolating the cause of a problem can be a key to successful intervention. That principle works in many contexts—including social policy.

Last summer, the Illinois legislature defeated a bill calling for mandatory Medicare assignment as a condition of medical licensure. The bill might be dead, but the issue is not. This period of relative calm offers a rare opportunity for arm-chair analysis.

Most of us would agree that quality health care for our elderly population is a reasonable goal.

A majority would also agree that mandatory Medicare assignment is not the way to get there. But how did we get to mandatory assignment?

Mandatory assignment is a product of the same kind of thinking that brought us DRGs. Or more precisely, the same allegiance to formulaic solutions to human problems.

I've heard it estimated that only about 30% of Illinois physicians are "participating" (*i.e.*, agree to take

assignment 100% of the time). But over 60% of Medicare claims filed in this state are assigned. That number doesn't surprise me, and it probably doesn't surprise many of you.

We physicians have always done our own "means tests." We all have patients who genuinely can't afford to pay more than Medicare's allowed amount. Medicine is a highly human endeavor, and that assessment is a part of the healing art. We don't need a formula to know when someone needs a helping hand. And we don't need a mandate to know when it's our turn to extend it.

The Medicare program doesn't distinguish between a destitute wid-

ow living on Social Security and a multimillionaire. Like any formulaic system, it perpetuates inequity.

So, to return to our initial premise, public policymakers need to grasp some fundamentals. Mandatory assignment is a poor solution because it derives from a faulty premise. It grows out of the kind of mindset which fails to acknowledge that medicine is a human art. That physician-patient relationships are personal, and each one is unique. And that those of us who have chosen this profession can be trusted to look beyond the bottom line.

Let's make sure our patients know that.

A handwritten signature in cursive script that reads "Harry A. Springer".

Harry A. Springer, M.D.
President

THE VIEWBOX

CONTRIBUTING EDITOR TERRENCE C. DEMOS, M.D., PROFESSOR OF RADIOLOGY, DEPARTMENT OF RADIOLOGY, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was contributed by Shin I. Nam, M.D., attending radiologist, Veterans Administration Hospital, Hines, Illinois.

This 61-year-old man had an excretory urogram because of recurrent dysuria. His general health is good. Physical examination is normal.



Figure 1
Supine view of the abdomen shows curvilinear calcification in pelvis (arrows).



Figure 2
Cystogram shows a superior contour defect and adjacent round soft tissue mass (arrows).

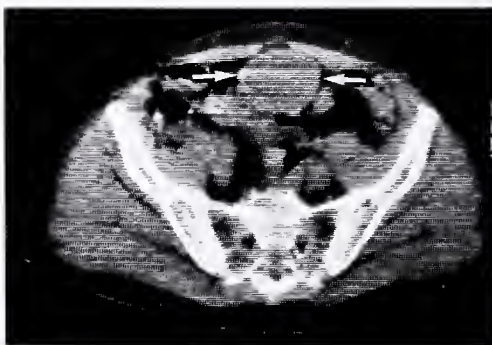


Figure 3
CT shows a mass (arrows) just superior to the bladder.

Your diagnosis?

1. Urachal cyst
2. Bladder diverticulum
3. Urachal sinus
4. Bladder carcinoma

(Continued on page 343)

Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

Contraindications: There are no known contraindications to the use of 'Tagamet'.

Precautions: While a weak antandrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlordiazepoxide, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.),

demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly un-

likely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only), and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

Liquid: 300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).

Injection:

Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage® Vials: 300 mg./2 ml. in single-dose, ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl (brand of cimetidine hydrochloride) injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

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OBITUARIES

***Allen, John P.**, Galesburg, died March 25, 1988, at the age of 45. Dr. Allen was a 1967 graduate of the University of Oregon Medical School, Portland.

****Bartz, Helen C.**, Ft. Myers, Florida, died March 26, 1988, at the age of 86. Dr. Bartz was a 1928 graduate of Rush Medical College, Chicago.

***Beguesse, Barry O.**, Chicago, died February 13, 1988, at the age of 69. Dr. Beguesse was a 1944 graduate of Meharry Medical College School of Medicine, Nashville.

****Caliendo, Joseph E.**, Chicago, died November 18, 1987, at the age of 78. Dr. Caliendo was a 1931 graduate of Loyola University Stritch School of Medicine, Maywood.

***Chandrasekharan, Rajamanickam**, Centralia, died November 27, 1987, at the age of 48. Dr. Chandrasekharan was a 1962 graduate of the Madras Medical College, Madras, India.

***Chapman, Robert A.**, Belleville, died January 18, 1988, at the age of 67. Dr. Chapman was a 1945 graduate of the University of Illinois College of Medicine, Chicago.

***Costanzo, Vincent A.**, Calumet City, died January 13, 1988, at the age of 79. Dr. Costanzo was a 1941 graduate of the University of Health Sciences/Chicago Medical School, Chicago.

DeBartolo, Hansel M., Aurora, died February 26, 1988, at the age of 72. Dr. DeBartolo was a 1942 graduate of the University of Health Sciences/Chicago Medical School.

Dougherty, Roderick J., Oak Park, died January 2, 1988, at the age of 77. Dr. Dougherty was a 1940 graduate of Loyola University Stritch School of Medicine.

****Drammis, John J.**, Chicago, died March 29, 1987, at the age of 88. Dr. Drammis was a 1922 graduate of Loyola University Stritch School of Medicine, Maywood.

***Garcia, Rogelio E.**, Lincolnwood, died February 15, 1987, at the age of 76. Dr. Garcia was a 1940 graduate of the Facultad de Medicina de la Universidad de la Habana, Havana, Cuba.

***Gawron, Walter W.**, Chicago, died October 7, 1987, at the age of 64. Dr. Gawron was a 1954 graduate of the Facultad de Medicina de la Universidad de Madrid, Madrid, Spain.

***Goodman, Maurice**, Laguna Hills, California, died September 21, 1987, at the age of 83. Dr. Goodman was a 1929 graduate of Loyola University Stritch School of Medicine, Maywood.

***Gordon, Harold**, Lincolnwood, died March 25, 1988, at the age of 62. Dr. Gordon was a 1954 graduate of the University of Illinois College of Medicine, Chicago.

***Grigaliunas, Yolanda**, Chicago, died July 6, 1987, at the age of 47. Dr. Grigaliunas was a 1966 graduate of the Facultad de Medicina de la Universidad Nacional de Columbia Ciudad Universitaria, Bogota, Cundinamarca, Columbia.

****Hoeksema, Henry**, Palos Heights, died September 18, 1987, at the age of 80. Dr. Hoeksema was a 1932 graduate of Rush Medical College, Chicago.

****Janson, Helge**, Glenwood, died November 16, 1987, at the age of 89. Dr. Janson was a 1925 graduate of Rush Medical College, Chicago.

Kaplansky, Mikhail, Maywood, died December 20, 1987, at the age of 47. Dr. Kaplansky was a 1966 graduate of the Vitebskij Medicinskij Institut, Vitebsk, U.S.S.R.

****Kittilsen, Lester H.**, Diamond City, Arizona, died December 6, 1987, at the age of 80. Dr. Kittilsen was a 1934 graduate of Loyola University Stritch School of Medicine, Maywood.

***Kloempken, Robert C.**, Huntley, died January 1, 1987, at the age of 65. Dr. Kloempken was a 1946 graduate of Loyola University Stritch School of Medicine, Maywood.

Kucharski, Stanley C., Arlington Heights, died December 30, 1987, at the age of 77. Dr. Kucharski was a 1935 graduate of the University of Health Sciences/Chicago Medical School, Chicago.

(continued on page 306)



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For Brief Summary, please see following page.

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Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

CONTRAINDICATIONS: DURICEF is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

WARNING: IN PENICILLIN-ALLERGIC PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF PENICILLINS AND CEPHALOSPORINS, AND THERE ARE INSTANCES OF PATIENTS WHO HAVE HAD REACTIONS TO BOTH DRUGS (INCLUDING FATAL ANAPHYLAXIS AFTER PARENTERAL USE).

Any patient who has demonstrated a history of some form of allergy, particularly to drugs, should receive antibiotics cautiously and then only when absolutely necessary. No exception should be made with regard to DURICEF (cefadroxil). **Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use.** Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Moderate to severe cases should be managed with fluid, electrolyte and protein supplementation as indicated. When the colitis is not relieved by drug discontinuance or when it is severe, oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should also be considered.

PRECAUTIONS: Patients should be followed carefully so that any side-effects or unusual manifestations of drug idiosyncrasy may be detected. If a hypersensitivity reaction occurs, the drug should be discontinued and the patient treated with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

DURICEF (cefadroxil) should be used with caution in the presence of markedly impaired renal function (creatinine clearance rate of less than 50 mL/min/1.73M²). (See Dosage and Administration section of Prescribing Information.) In patients with known or suspected renal impairment, careful clinical observation and appropriate laboratory studies should be made prior to and during therapy.

Prolonged use of DURICEF may result in the overgrowth of non-susceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug. DURICEF should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to 11 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cefadroxil. There are, however, no adequate and well controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Caution should be exercised when cefadroxil is administered to a nursing mother.

ADVERSE REACTIONS: *Gastrointestinal*—Symptoms of pseudomembranous colitis can appear during antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity—Allergies (in the form of rash, urticaria, and angioedema) have been observed. These reactions usually subside upon discontinuation of the drug.

Other reactions have included genital pruritus, genital moniliasis, vaginitis, and moderate transient neutropenia.

Before prescribing or administering, see package insert

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Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the

number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

June

Hematology/Oncology/Internal Medicine

Recent Advances in the Diagnosis and Management of Malignant Disease

For: Internists, hematologists, oncologists, and interested physicians. Course, June 22-24, Chicago, IL. **Sponsor:** Rush Cancer Center, Rush-Presbyterian-St. Luke's Medical Center, 1725 W. Harrison Street, Chicago, IL 60612. **Fee:** Varies. **Credit:** Category 1: 17-¼ hours. **Contact:** American College of Physicians Registration Services. **Phone:** (800) 523-1546.

Obstetrics/Gynecology

Obstetrics and Gynecology Review Course

For: OB/GYN's. Course, June 13-18, Chicago. **Sponsor:** University of Chicago, Center for Continuing Medical Education, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** \$550. **Reg. Limit:** 300. **Credit:** Category 1: 39 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Occupational Medicine

Occupational Disorders of the Upper Extremities

Lecture, June 27-29, Oak Brook, IL. **Sponsor:** Loyola University of Chicago, 2160 S. First Avenue, Maywood, IL 60153. **Fee:** \$250. **Credit:** Category 1: 17 hours. **Contact:** Division of Continuing Medical Education. **Phone:** (312) 531-3236.

Ophthalmology

Corneal Surgery for the Anterior Segment Surgeon: Hands-On Workshop

For: Ophthalmologists. Workshop, June 24-25, Chicago. **Sponsor:** The Cornea Service, Dept. of Ophthalmology, Rush-Presbyterian-St. Luke's Medical Center, 1753 W. Congress Parkway, Chicago, IL 60612. **Fee:** \$300. **Reg. Limit:** 100. **Credit:** Category 1: 16 hours. **Contact:** Victoria O'Sullivan, University Office of CME, 600 S. Paulina, Chicago, IL 60612. **Phone:** (312) 942-7119.

Contact Lens Course

For: Ophthalmologists. Course, June 17-18, University of Illinois Hospital, Eye & Ear Infirmary, Chicago. **Sponsor:** University of Illinois College of Medicine, Dept. of Ophthalmology, 912 S. Wood, Chicago, IL 60612. **Fee:** \$150. **Reg.**

Limit: 200. **Credit:** Category 1: pending. **Contact:** Conference Registrar. **Phone:** (312) 996-5225.

Otolaryngology

Endoscopic Sinus Surgery Workshop

For: Otolaryngologists. Workshop, June 17-18, Chicago. **Sponsor:** University of Chicago School of Medicine, Office of Continuing Medical Education, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** 60. **Credit:** Category 1: To be determined. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Pathology

Seminar on New Technology

For: Pathologists. Lecture, June 13, Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644 and Michael Reese Hospital and Medical Center. **Fee:** None. **Credit:** Category 1: 2 hours for Chicago Pathology Society members only. **Contact:** Marshall H. Short, M.D. **Phone:** (312) 626-4300, Ext. 5720.

July

Allergy

Clinical Allergy for the Practicing Physician

For: Physicians. Seminar, July 21-23, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** \$175. **Reg. Limit:** 150. **Credit:** Category 1: 15 hours; AAFP Prescribed: 15 hours; and ADA: 15 hours. **Contact:** Loretta Giacometto. **Phone:** (800) 325-9862.

August

Surgery, Ophthalmology, Dermatology

Laser Use and Safety Issues

For: Physicians and other health professionals. Conference, August 25-26, Madison, WI. **Sponsor:** University of Wisconsin-Madison, Continuing Medical Education, 2715 Marshall Court, Madison, WI 53705. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1: 10 hours; AOA Category 2-D: 10 hours; University of Wisconsin CEH: 10 hours. **Contact:** Cathy Means, Program Coordinator. **Phone:** (608) 263-6637.



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It means "dependability" in almost any language

*Based on worldwide sales data on file, CIBA Pharmaceutical Company.
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Before prescribing, please consult Brief Prescribing Information on next page.

C I B A

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For patients who can't or won't tolerate liquid KCl.

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†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

C I B A

References: 1. Data on file, CIBA Pharmaceutical Company. 2. Skoutakis VA, Acchiaro SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. 3. Skoutakis VA, Carter CA, Acchiaro SR: Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

Slow-K[®]
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Slow-Release Tablets
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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

INDICATIONS AND USAGE
BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, and certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS

Hyperkalemia (See OVERDOSAGE).

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients

Physicians should consider reminding the patient of the following:

- To take each dose without crushing, chewing, or sucking the tablets.
- To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.
- To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS), other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, excretory mechanisms are impaired or if potassium is administered to rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by a characteristic electrocardiographic changes (peaking of T waves, loss of P wave depression of S-T segment, and prolongation of the Q-T interval). Latent manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED

Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, but colored, sugar-coated (imprinted Slow-K)

800 tablets of 100	NDC 0083-0165-30
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Accu-Pak [®] Unit Dose (8 blister pack)	
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Conference on Resident Working Hours

BY BRUCE DOBLIN, M.D., CHAIRMAN, ISMS-RPS

On Saturday, May 21, the ISMS Resident Physicians Section will sponsor a forum on resident stress and working hours. It will be held at the headquarters office of the Illinois State Medical Society, Twenty North Michigan Avenue, from 1:00 p.m. to 5:00 p.m. Despite a temporary respite in deliberations, many complex issues remain regarding the future structure of medical residencies. The questions abound:

- What is the appropriate mode of resident supervision?
- Must there be in-house attendings at all times?
- How many continuous hours can a resident work and continue to provide good patient care?
- How long should the work week be?
- How will a reduction in resident work hours be financed?

- What are the greatest sources of resident stress and how can they be reduced?

We have organized an excellent panel to discuss these questions. The six panel members represent a broad cross-section of perspectives regarding graduate medical education.

- Dr. Michael Laufer, an emergency medicine resident at Harbor-UCLA Medical Center and a member of the AMA-RPS Governing Council.
- Mr. Steven Jesser, J.D., Northwestern Memorial Hospital general counsel with seven years' experience in health care law.
- Lauren G. Sharp, Ph.D., medical affairs program director, American Hospital Association.
- Dr. Jeffrey Glassroth, chief of medicine, Northwestern Memorial Hospital.

- Ms. Cynthia Scott, a consultant on graduate medical education and a national expert on resident stress.
- Dr. Frank Davidoff, associate vice president for education, American College of Physicians, and professor of medicine, Cornell Medical Center.

The panel was constructed to represent the viewpoints of the resident, the residency director, the health care lawyer and the hospital director. Panelists include experts on resident stress and the landmark Bell Commission (which has recommended a major restructuring of residency programs for the State of New York). Following the moderated panel discussion there will be a question and answer period, and a concluding reception.

The program is open to medical students, residents, residency pro-

gram directors and interested individuals. This issue is of importance to everyone within the medical community. Unless reform comes from within the medical profession itself, changes in medical education may very well be legislated in individual states around the country. To date, 22 states have introduced legislation regarding this topic. Recently, the Bell Commission, made up of residency program directors in New York State, recommended to the New York State Department of Public Health that dramatic changes be made in resident schedules. They proposed a 12-hour limit on emergency room shifts, a 16-hour limit of resident shifts outside of the emergency room, breaks in

work of no less than 8 hours, and restrictions on moonlighting.

These issues are of such paramount importance that the *New England Journal of Medicine* devoted over ten pages of its "Sounding Board" to the topic in its March 24, 1988 issue. "Job stress has grown," writes Dr. Timothy B. McCall from Cambridge, Massachusetts, "and stress reduction measures may not be enough. Unless they are combined with fundamental changes in residency training, such measures will act only as band-aids. The fundamental problem is not that residents need outlets for their stress," he concludes. "Rather, it is simply that their working conditions create too much stress."

This is not just an issue which involves medical educators and residents in training, write Drs. Asch and Parker from Philadelphia, Pennsylvania. Hospital administrators, they suggest, "have powerful incentives to embrace these (work shift) systems, because the implementation of shift hours undermines physicians' power: the fragmented, production-line approach to continuous care increases the substitutability of physicians, making each one more replaceable."

Please save four hours of the afternoon of Saturday, May 21, 1988 and plan on attending an open discussion about this critically important issue. ◀



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Obits

(continued from page 298)

****Loef, John A.**, Bexley, Ohio, died July 19, 1987, at the age of 81. Dr. Loef was a 1931 graduate of Loyola University Stritch School of Medicine, Maywood.

***Marti, Enrique**, Arlington Heights, died January 5, 1987, at the age of 61. Dr. Marti was a 1953 graduate of Facultad de Medicina, Universidad de Valencia, Valencia, Spain.

Martin, Richard R., Peoria, died October 17, 1987, at the age of 79. Dr. Martin was a 1938 graduate of Loyola University Stritch School of Medicine, Maywood.

McLane, William L., Tolono, died December 5, 1987, at the age of 70. Dr. McLane was a 1944 graduate of Jefferson Medical College of Thomas Jefferson University.

***Mendelsohn, Robert S.**, Evanston, died April 5, 1988, at the age of 61. Dr. Mendelsohn was a 1951 graduate of the University of Chicago Pritzker School of Medicine.

Mikhail, Kamel A., Berwyn, died January 29, 1988, at the age of 58. Dr. Mikhail was a 1954 graduate of the Ibrahim Pasha University Faculty of Medicine, Cairo, Egypt.

***Miner, John O.**, Joliet, died October 25, 1987, at the age of 69. Dr. Miner was a 1951 graduate of the University of Cincinnati College of Medicine, Ohio.

Mulvill, James E., Alton, died November 9, 1987, at the age of 78. Dr. Mulvill was a 1942 graduate of the University of Health Sciences/Chicago Medical School.

***O'Reilly, Curt M.**, Palos Heights, died July 31, 1987, at the age of 66. Dr. O'Reilly was a 1948 graduate of Loyola University Stritch School of Medicine, Maywood.

****Oslay, Francis A.**, Aston, died April 5, 1988, at the age of 76. Dr. Oslay was a 1935 graduate of the Orvosi Fakultas Tudományegyetem, Budapest, Hungary.

***Padnos, Emanuel**, Hollywood, Florida, died January 4, 1987, at the age of 84. Dr. Padnos was a 1929 graduate of the University of Illinois College of Medicine, Chicago.

****Pronger, Earle J.**, Atlantis, Florida, died April 2, 1988, at the age of 90. Dr. Pronger was a 1923 graduate of the Northwestern University Medical School, Chicago.

***Renz, Theodore H.**, Chicago, died March 21, 1988, at the age of 74. Dr. Renz was a 1940 graduate of Loyola

University Stritch School of Medicine, Maywood.

****Robinson, Stanley E.**, Prophetstown, died February 4, 1988, at the age of 81. Dr. Robinson was a 1937 graduate of the University of Illinois College of Medicine, Chicago.

***Rodriguez, Ignacio A.**, Chicago, died November 11, 1987, at the age of 64. Dr. Rodriguez was a 1947 graduate of the Facultad de Medicina de la Universidad de la Habana, Havana, Cuba.

****Rosi, Peter A.**, Chicago, died December 11, 1987, at the age of 85. Dr. Rosi was a 1928 graduate of Rush Medical College, Chicago.

****Smith, Kenneth J.**, Blue Island, died August 2, 1987, at the age of 82. Dr. Smith was a 1930 graduate of the University of Illinois College of Medicine, Chicago.

***Stutzman, Robert L.**, Bloomington, died April 7, 1988, at the age of 58. Dr. Stutzman was a 1956 graduate of the University of Illinois College of Medicine, Chicago.

Vanderbeck, James J., Chicago, died November 29, 1987, at the age of 82. Dr. Vanderbeck was a 1933 graduate of Georgetown University School of Medicine, Washington D.C.

****Varzino, Louis S.**, Oakbrook, died October 8, 1987, at the age of 81. Dr. Varzino was a 1932 graduate of the University of Illinois College of Medicine, Chicago.

****Wacker, Maxwell N.**, died December 21, 1987, at the age of 80. Dr. Wacker was a 1934 graduate of the University of Illinois College of Medicine, Chicago.

****Wallner, Linden J.**, Highland Park, died September 25, 1987, at the age of 83. Dr. Wallner was a 1928 graduate of Loyola University Stritch School of Medicine, Maywood.

Weiss, Andrew E., Peoria, died November 12, 1987, at the age of 48. Dr. Weiss was a 1967 graduate of the University of Cincinnati College of Medicine, Cincinnati, Ohio.

****Weiss, Jack A.**, Chicago, died November 28, 1987, at the age of 85. Dr. Weiss was a 1925 graduate of Rush Medical College, Chicago.

***Wolf, William S.**, Lake Geneva, Wisconsin, died March 14, 1988, at the age of 70. Dr. Wolf was a 1942 graduate of Loyola University Stritch School of Medicine, Maywood. ◀

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Please see adjoining page for references and brief summary of prescribing information.

*Significantly greater than cimetidine smoker group ($P < .05$).

0825A8



MEDICAL STUDENT SECTION IN ACTION

BRIEF SUMMARY

CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate.

PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility:

Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

Pregnancy: Teratogenic effects. Pregnancy Category B.

Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

OVERDOSAGE

There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

DOSE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED

CARAFATE (sucralfate) 1-gm tablets are supplied in bottles of 100 (NDC 0088-1712-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1712-49). Light pink scored oblong tablets are embossed with CARAFATE on one side and 1712 bracketed by C's on the other.

Issued 1/87

References:

1. Korman MG, Shaw RG, Hansky J, et al. *Gastroenterology* 80:1451-1453, 1981.
2. Korman MG, Hansky J, Merrett AC, et al. *Dig Dis Sci* 27:712-715, 1982.
3. Brandstaetter G, Kratochvil P. *Am J Med* 79 (suppl 2C):36-38, 1985.
4. Marks IN, Wright JP, Gilinsky NH, et al. *J Clin Gastroenterol* 8:419-423, 1986.
5. Lam SK, Hui WM, Lau WY, et al. *Gastroenterology* 92:1193-1201, 1987.



0825A8

Aging: A New Fad

By STEVEN E. RUBIN, SIU SCHOOL OF MEDICINE

The recent plethora of anti-aging skin care products demonstrates to the observer that aging has become a "fad." America's people are aging, and new attention is being directed at the 29 million consumers 65 years of age or older.

A three-digit lifespan is like a dangling carrot for both the medical and business professions. As science and technology advance to prolong health, commerce will serve to accommodate the needs and luxuries of the populace. To confront evolving ethical and quality of life issues, there continues to be a rapid growth in the geriatric-oriented job market. The drive to heal and care has interfaced with making a buck.

Many of the results have been good, and society's awareness of the elderly is increasing. Conscientious politicians convey support for improved retirement services and continued research in diseases of aging. Mass media provides up-to-date information about the nation's elderly crises across magazines, newsprint, and the airwaves. Television is keeping pace with the aging market share as seen by the increased frequency with which commercial advertisers are using older spokespersons to sell prod-

ucts. The elderly are selling soft drinks and alcohol, fast-food, medicine, and automobile oil.

Americans are tuning in their television sets on Saturday evenings to laugh along with four elderly women retired in Florida, yet our nation continues to experience an increasing rate of suicide by people aged 65 years or older. Crime, poverty, and worse yet, loneliness, continue to plague a generation that has weathered a lifetime of experience only to be treated as a nuisance to society, and sometimes to their own families.

So the issue is deeper than commercialization of an aging generation. The efforts by scientists, public figures, the media, health care providers, and so on, are welcomed and necessary. At the same time, we as individuals need to assume new responsibility for our elders by not leaving the care of the elderly solely to government and business. The old and infirm deserve personal care, which means individual contributions, and not just an exploitation as a growing market power. While ethicist Daniel Callahan may claim that limits should be set as to how much care will be provided, so too must limits be set as to how little.



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A Case for a Tickler File

Will You Renew Your Contract or Will It Renew Itself?

By JUDEE GALLAGHER, J.D./CHICAGO

Do you have a tickler file to jog your memory well in advance of every contract renewal date? If not, you may be locked into a contract relationship for another year (or more) that has not met your expectations or is harmful to your practice. Unlike many contracts which expire at a given date, HMO and PPO contracts usually *automatically* renew at a given date. Generally, automatic renewals place the physician at a disadvantage by forcing him or her to terminate the contract in order to negotiate new terms. It may be difficult to rid yourself of automatic renewal clauses by negotiation. But it is possible to live with them and prosper.

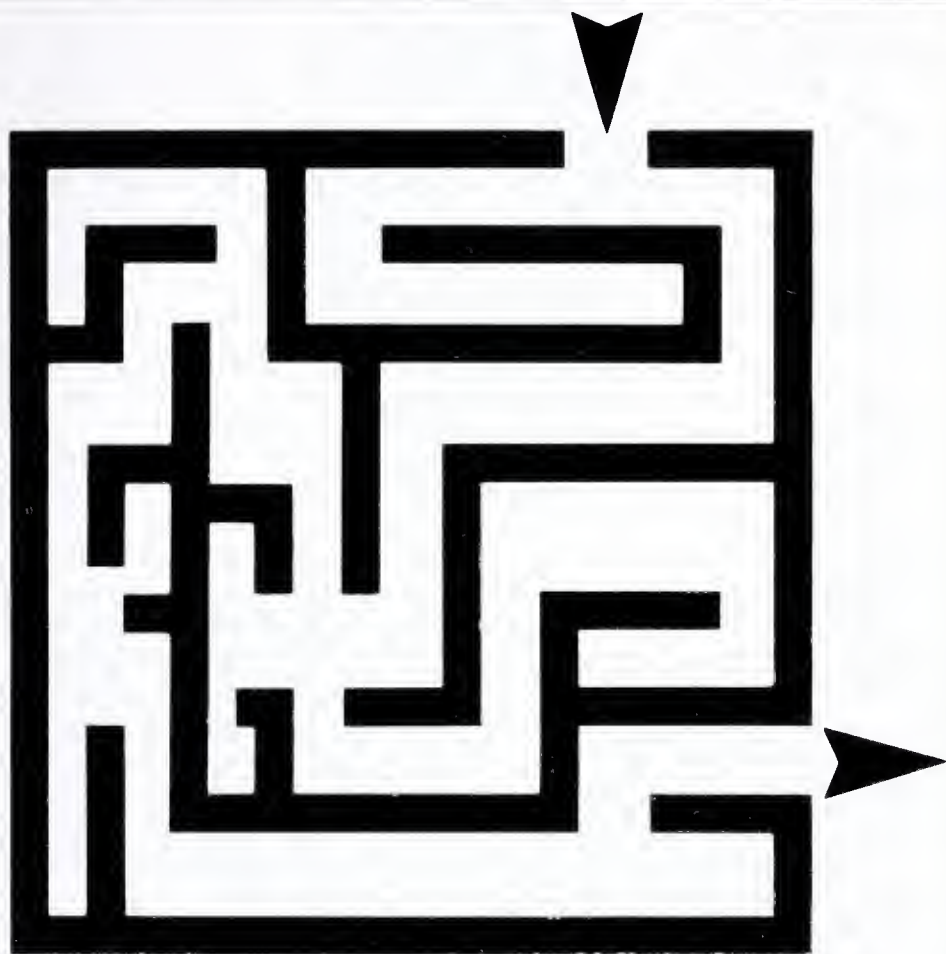
First, the contract will not automatically renew *if* you notify your contractor in writing by a certain date that you want to terminate the

contract. Your tickler file can alert you to those dates, giving you time to thoughtfully evaluate each contract's effect on your practice. Secondly, if you set up a separate file to track the financial impact of each contract and show the effects of various cost containment programs on your practice, you have information to make an informed decision regarding renewal. This knowledge is a good tool in contract negotiations. By comparing your performance under different contracts, those which are not meeting your objectives may stand out clearly. Remember: You need not renew every contract.

What is the economic impact of the contract on your practice? You will be able to evaluate whether you are receiving adequate reimbursement if you have monitored your experiences. One way to do this

might be to prepare visit charge slips similar to those used for non-contract patients. File the slips in that particular HMO's or PPO's "experience file." If you are compensated by capitation payments, compare the charges incurred by contract patients with the total capitation received from the HMO. Compare your performance under this particular capitation arrangement with your other capitation contracts and your fee-for-service experience.

How do your actual costs compare with your compensation arrangements? Is the HMO or PPO adjusting your reimbursement to account for increased costs in the upcoming contract year? Has the HMO added new services as plan benefits without a corresponding increase in the capitation rates? Has the PPO expanded covered ser-



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vices, resulting in an extension of your fee discount to new services?

What about copayments? In a capitated system you are paid a fixed amount per enrollee regardless of utilization. A copayment increase may discourage patient over-utilization of some services, thereby decreasing your costs. In a PPO, typically, the copayment is automatically subtracted from the amount the PPO pays you. If you are having difficulty collecting copayments, your compensation is less than what you bargained for. What measures are available to assure that copayments will be paid? Can you collect a security deposit or some other assurance of payment? Does the HMO or PPO pay you promptly?

How do the projected utilization rates for specialty and hospital care compare with the plan's actual experience? Generally, the percentage amount withheld from your compensation is "at risk" to pay for care rendered which exceeds the utilization projections. If your utilization rate consistently exceeds the rate set by the plan, and your medical decisions cannot be characterized as "over-utilization," consider whether the plan rates are too low for the patient population. Critically examine the actuarial assumption underlying the plan rate. Determine whether you can render good quality medicine and meet your ethical and legal obligations to your patients under the plan's economic constraints. Evaluate the percentage of premium kept by the plan in light of its "risks" and responsibilities. Finally, how many HMO members have chosen you to provide care? In

capitation systems the risks generally decrease as the number of members who have chosen you increase. Do you have enough members to absorb the administrative costs of serving plan members?

What is the impact of the plan's cost containment program? Can you practice good quality medicine within its restrictions and limitations? Are the severity of illness criteria consistent with professional medical standards? Do disputes regarding the "medical necessity" of a referral, procedure or course of treatment occur frequently? Is the plan's interpretation of a "medical emergency" consistent with good medical practice? Is there an appeals procedure which is prompt, fair and neutral to contest medical necessity denials? The "standard of care" defining your duty to your patients remains the same regardless of the contract. Your "standard of care" is not diminished by cost containment programs. Frequent "medical necessity" disagreements may indicate that the plan's cost containment efforts are at odds with your responsibility to provide care according to professional standards. Does the prior authorization system run smoothly? Or are the procedures overly burdensome and time consuming? Do plan personnel respond promptly to prior authorization requests?

If you are not satisfied with the answers to these questions, it may be time to notify the HMO or PPO that you intend to terminate the contract. Remember, with automatic renewals you must take the first step.

Because you're an informed phy-

sician who recognizes the complex issues involved in contracts for the delivery of medical care, your first step is to send the contract offered you or your IPA to the ISMS Office of Contractual Services. As a *members only service*, the office will provide you objective comments on any HMO, PPO or IPA contract for the nominal fee of \$100. Contract reviews highlight "standard of care," compensation and insurance issues, and pinpoint ambiguous language and inconsistent or contradictory provisions.

The review is a basic tool to help understand the contract. It's a good first step, but never a substitute for careful reading of the contract itself. It's not legal advice and the office cannot recommend that any contract is good or bad and should or shouldn't be signed. Each physician (or physician's corporation or partnership) must make that decision. The informed physician's personal attorney and accountant must be consulted before decisions are made.

Your attorney has undoubtedly explained that when you are considering an Individual Participation Agreement with an HMO, PPO or IPA you may not band together with other physicians to negotiate the contract collectively, because that violates antitrust laws. You can, however, individually negotiate your own contract by yourself or with your personal attorney or financial advisor. ◀

Judee Gallagher, J.D., is a Chicago private practice attorney retained by the ISMS Office of Contractual Services since 1985.



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Balloon Dilatation for Mitral Stenosis

By TED E. FELDMAN, M.D., DAVID M. BRILL, M.D., KOK GEE CHUA, M.D. AND JOHN D. CARROLL, M.D./CHICAGO

Catheter balloon valvuloplasty is a new technique for the treatment of critical cardiac valvular stenosis in adult patients. Catheter dilatation may be performed in patients at high risk for surgical valve replacement, such as those with severe left ventricular failure or chronic lung disease. It has been employed successfully in patients with calcified valves without causing either embolization or valve insufficiency. In addition, it may be employed in patients with mitral valve stenosis, for whom surgical commissurotomy has been the usual therapy. We report two patients with critical mitral valve stenosis, in whom catheter balloon dilatation was performed using a double balloon technique. This report discusses important issues for case selection and describes the technique of percutaneous mitral valvuloplasty.

Although surgical mitral valve replacement or mitral commissurotomy has been successful therapy for many patients with critical mitral stenosis, there are compelling reasons for the development of new techniques. Some patients fall into a high risk group for surgery. For these patients a palliative technique with lower risk would expand the therapeutic options available to both physician and patient. Catheter balloon valvuloplasty is being developed as an alternative nonsurgical therapy for these high risk patients, who previously faced very high surgical mortality, or might have been denied surgery. Secondly, it is desirable to avoid or delay surgery because of its morbidity and cost. Balloon valvuloplasty

requires study to determine whether the efficacy, morbidity, and mortality of the technique are comparable to simple surgical commissurotomy in otherwise healthy patients.

We describe two patients who illustrate the important aspects of case selection, the current state of the technique of mitral balloon valvuloplasty, and early hemodynamic results.

Case Reports

The first patient is a 77-year-old woman, admitted with pulmonary edema, with a history of episodic pulmonary congestion dating back many years. She gave no history of rheumatic fever, but was found to have mitral stenosis. Systemic blood pressure was 124/80mmHg, and

the heart rate 84 beats/min, which was regular. The carotid upstroke was normal and there were no arterial bruits. Basilar rales were heard over both lung fields. The first heart sound was increased in intensity; S₂ was narrowly split; P₂ was increased in intensity. An opening snap was heard 0.08 seconds after P₂, followed by a grade 2/4 diastolic rumble with presystolic accentuation.

The ECG showed sinus rhythm, left atrial enlargement, and incomplete right bundle branch block. Chest radiograph showed small bilateral pleural effusions, mild pulmonary venous distension, and left atrial and pulmonary artery enlargement. On fluoroscopic exam the mitral valve and annulus were heavily calcified. Echocardiographic and Doppler exams showed a calculated mitral valve area of 1.1cm², no significant mitral regurgitation, marked left atrial enlargement, and low normal left ventricular systolic performance. There was trivial aortic regurgitation. The mitral leaflets were markedly thickened.

Valve Dilatation

The patient gave written informed consent in accordance with a protocol approved by the clinical investigation committee of our institution. Mitral valve dilatation was accomplished via the transseptal, antegrade approach. A transseptal puncture was performed with

a Ross needle and Brockenbrough catheter introduced from the right femoral vein. A Mullin transseptal sheath was exchanged for the Brockenbrough catheter and a flotation catheter was inserted into the sheath and advanced from the left atrium to the left ventricle and the ascending aorta. A 260cm guidewire was passed through the flotation catheter to the descending aorta and an 8mm diameter, 3cm long balloon catheter was exchanged over the wire and was used to dilate the interatrial septum. A single inflation was performed to 3-5 atmospheres. Using a double-lumen catheter, a second 260cm guidewire was positioned across the mitral valve through the left ventricle to the ascending and descending aorta. A 20mm diameter, 3cm long balloon catheter was exchanged for the 8mm balloon and was passed antegrade across the mitral valve. A second 20mm diameter, 3cm long balloon catheter was also passed across the mitral valve. Five simultaneous inflations of both balloon catheters to 3-5 atmospheres were performed. Blood pressure declined transiently with each simultaneous inflation. An indentation from the stenotic valve was not present on the balloon profile during initial inflation; it is likely that the commissures opened as the balloon expanded. The mean gradient before valvuloplasty was 8mmHg with a cardiac output of 3.2L/min. (thermodilution method) at a heart rate of 75; the calculated valve area was 1.0cm². After valvuloplasty the mean gradient was 4.4mmHg at a substantially higher cardiac output of 4.65L/min. and a heart rate of 80. The calculated valve area was 2.5 cm². (Figure 1) Left ventriculography revealed that the degree of mitral regurgitation was unchanged at "trace" compared to the pre-valvuloplasty study. Oximetry demonstrated that no left-to-right intra-cardiac shunt resulted from the transseptal passage of catheters.

The second patient is a 46-year-old woman with a history of rheumatic fever at age 18 years. She developed dyspnea on exertion in her third decade and a cardiac catheterization revealed moderate mitral stenosis and mild aortic insufficiency. At the age of 45 years she

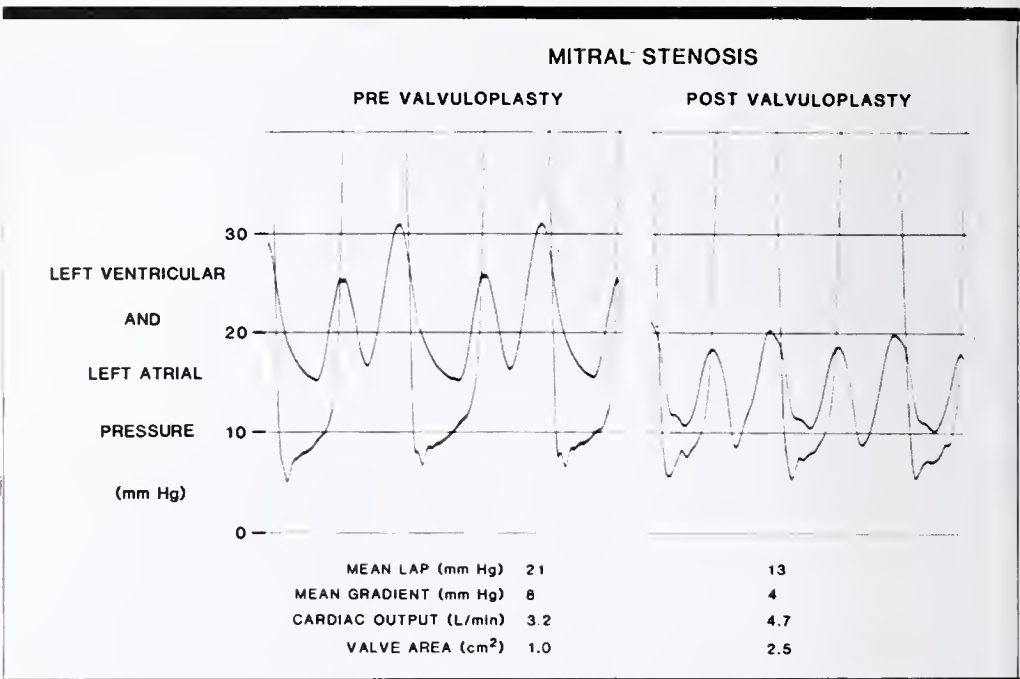


Figure 1
Left ventricular and left atrial pressures from patient one before and after mitral valvuloplasty using the double balloon technique. The diastolic gradient is decreased after valve dilatation, with a resultant increase in both cardiac output and valve area.

had progressive dyspnea on exertion with symptoms occurring after walking less than two blocks. Blood pressure was 95/60mmHg with a heart rate of 64, which was regular. The carotid upstroke was slightly delayed. The lungs were clear. The

first heart sound was increased in intensity; P₂ was equal to A₂ in intensity. There was a grade 2/4 early- to mid-diastolic rumble at the apex, a grade 2/4 blowing diastolic murmur at the base and left sternal edge, and a grade 2/6 systolic ejec-

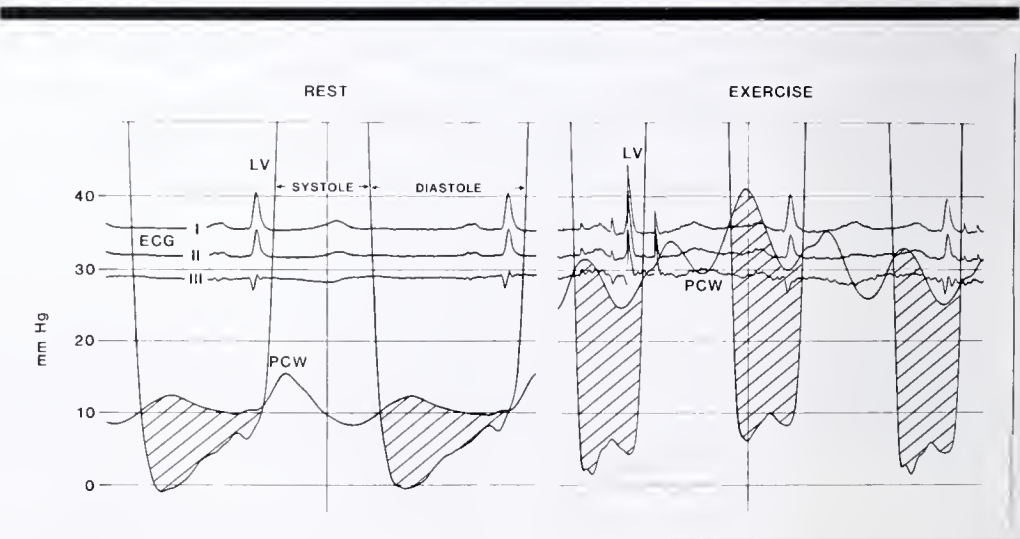


Figure 2
Simultaneous left ventricular and pulmonary wedge pressure recordings before and after exercise in patient two. Before exercise there is a mean diastolic gradient of 5.2mmHg (shaded area) between the left ventricle (LV) and pulmonary wedge (PCW), or left atrial, pressure. After exercise the mean diastolic gradient increases to over 8mmHg.

tion murmur. The rhythm was sinus bradycardia on the electrocardiogram. Chest radiograph revealed left atrial enlargement and pulmonary venous congestion. Fluoroscopy showed no significant mitral calcifications.

Echocardiographic and Doppler exams demonstrated a noncalcified stenotic mitral valve with an estimated valve area of 1.2 cm². There was 2+ aortic insufficiency.

On cardiac catheterization there was a mean diastolic gradient across the mitral valve of 9.5mmHg, with a cardiac output of 3.6L/min (Fick method). The calculated valve area was 1.1 cm², using the Gorlin formula. Mild mitral regurgitation was present on left ventriculography. After three minutes of supine exercise on a leg ergometer at 100 kilopounds per meter, the pulmonary capillary wedge pressure increased from a baseline value of 14mmHg to 31mmHg, the mean diastolic gradient measured 21mmHg, and the cardiac output

increased to 6.2L/minute. (Figure 2)

Valve Dilatation

Mitral valve dilatation was performed using the same basic approach as described above. After transseptal puncture and passage of two long guidewires from the right atrium, through the interatrial septum, left atrium and ventricle and into the descending aorta, two 20mm diameter, 5.5cm long balloon catheters were passed antegrade across the mitral valve. A simultaneous inflation of both balloon catheters to 3-5 atmospheres was performed. (Figure 3) Another simultaneous inflation was subsequently done with two 20mm diameter, 3cm long balloon catheters. The blood pressure declined precipitously and transiently with each simultaneous inflation. An indentation denoting the stenotic valve was present on the inflated balloon profile and failed to completely disappear despite full inflation of both balloons. The mean gradient before valvuloplasty was 5.2mmHg with a cardiac output of 3.6L/min (thermodilution method) at a heart rate of 62; the calculated valve area was 1.1 cm². After valvuloplasty the mean gradient was 8.2mmHg at a substantially higher cardiac output of 4.65L/min and a heart rate of 91. The calculated valve area was 1.7cm². Left ventriculography revealed that the degree of mitral regurgitation was unchanged at 1+ compared to the prevulvuloplasty study. After removal of the transseptal apparatus, a complete right sided oxygen saturation study showed no shunting at the atrial level.

Discussion

Catheter balloon valvuloplasty was initially applied in children with pulmonic valve stenosis.¹ Young patients with rheumatic mitral stenosis and children and young adults with congenital aortic stenosis were treated shortly thereafter.²⁻⁴ Concern about embolization of valve fragments necessitated a deliberate approach to balloon dilatation of calcified valves in older patients. Early reports of successful mitral valve dilatation have made it clear that the procedure can be per-

formed with adequate safety and efficacy in adult patients.^{5,6}

Results of Mitral Valvuloplasty

Dilatation of the mitral valve results in increased cardiac output, decreased transmitral valve pressure gradient, left atrial pressures, pulmonary wedge and pulmonary artery pressures, and increased mitral valve area. Increases in mitral area are from less than 1.0cm² prevulvuloplasty, to an average of 1.6cm² to 2.4cm² afterwards (range up to 3.5cm²).⁵⁻⁷ The results in the two patients described in this report are typical of current experience. It is important to note that mitral valve prostheses have average *in vivo* areas from 1.7cm² to 2.5cm².⁸

There have been relatively few major complications of the procedure reported. Since valvuloplasty is performed using the transseptal approach, cardiac perforation is a risk. Dilation of the interatrial septum to allow passage of the large balloons has resulted in atrial septal defect in some patients. These defects are usually small, though a left-to-right shunt as large as 2.3-to-1 has been described.⁶ The presence of an interatrial communication may also allow decompression of elevated left atrial pressure even without relief of the mitral stenosis. This remains an important consideration when evaluating the final results of the procedure. An additional consideration in this regard is the effect such a shunt will have on the cardiac output. Use of the Fick method, with measurement of blood oxygen content in the systemic venous system and multiple cardiac chambers, rather than thermodilution cardiac output measurement, is essential to detect and quantify a left-to-right shunt. Thromboembolic episodes seem rare. This may be due in part to the meticulous care taken to be sure patients have at least four weeks of anticoagulation prior to valvuloplasty, and the use of screening echocardiographic examination to detect left atrial thrombus. Transient complete heart block has been described after dilatation, due to the close proximity of the mitral annulus to the A-V node and His bundle. Significant mitral regurgitation has been an



Figure 3
Inflated balloons across the mitral valve. The balloons are indented by the stenotic valve orifice. The guidewires traverse the entire circulation. At the left of the picture they come up through the inferior vena cava, then cross from the right atrium (RA) through the interatrial septum to the left atrium. The balloons cross from the left atrium into the left ventricle (LV). The wires then loop in the left ventricle, cross the aortic valve, and traverse the aortic arch to the descending aorta (AO) at the right of the picture.

infrequent finding, even in patients with calcified, nonpliable valve leaflets.

Patient Selection

Those patients for whom mitral valve replacement would be the traditional therapy must be considered separately from those likely to benefit from mitral commissurotomy. Candidates for valve replacement are one group for whom mitral valvuloplasty is well suited if no significant regurgitation is present. This is usually because of an inability to perform commissurotomy due to extensive changes in the valve and subvalvular structures, and the presence of factors that increase risk for surgery, such as advanced age, pulmonary or renal disease, or multi-organ system disease. The risks and benefits of surgery and long term anticoagulation must be contrasted with those of valvuloplasty in this group. Among the first 65 adult patients reported, there has been one death (1.5%) following emergency valve replacement after a failed mitral valvuloplasty procedure.⁵⁻⁷ Operative mortality for mitral valve replacement is reported to be 5%-10%.⁹ Whether a high rate of restenosis will limit the long term benefits of valvuloplasty in this group remains to be studied.

Younger patients with non-calcified valve leaflets and no significant risks for operation would usually have a good result from mitral commissurotomy, and are also spared the long term risks of a prosthetic valve. In the initial stages of the development of valvuloplasty a single balloon was used, and the resultant valve areas were smaller than those achieved with commissurotomy. The introduction of double balloon dilatation has eliminated this difference in procedural results,⁷ recognizing that commissurotomy usually results in valve areas of about 2cm², while valve prostheses usually have areas between 1.7 and 2.5cm².⁸ Restenosis remains a problem for patients undergoing surgical commissurotomy,¹⁰ and will certainly occur after balloon valvuloplasty.¹¹ Younger patients with a pliable, minimally calcified valve and no mitral regurgitation have been ideal candidates for surgical commissurotomy. Balloon therapy

may be best suited for these ideal patients as well. At present, it is not possible to predict which patients will have optimal results after valvuloplasty. Patient two in this report, though improved symptomatically, had a final valve area under 2cm². It is critical to improve our ability to select patients best suited to each available therapy.

Mechanism of Relief of Mitral Obstruction

Postmortem and intraoperative studies have shed some light on the mechanism of valve dilatation.^{6,12} The major result of balloon inflation is commissural splitting. Fracture of calcific nodules on the commissures and leaflets has also been described.⁶ Patient one in this report had immediate disappearance of the valve indentation on the inflated balloons, while patient two had persistent indentation of the balloons. This failure of resolution of the balloon indentation from the stenosed valve leaflets may be an important marker for success of the procedure. It is possible to predict which patients will likely have the better response to dilatation based on echocardiographic exam. Those with less calcification in the subchordal apparatus do best.

Clinical Implications

Mitral valvuloplasty may be accomplished safely and successfully in symptomatic patients with mitral stenosis. Patients previously considered high risk for valve replacement now have an available therapeutic option. In addition, an alternative is available for those patients who refuse surgery or anticoagulant therapy. The long term results of mitral valvuloplasty are not known. Mitral valvuloplasty therefore remains an experimental therapy undergoing intense investigation at selective institutions. Whether valvuloplasty has a restenosis rate less than the 10%-50% reported for commissurotomy¹³ will be determined only by careful study of the patients currently undergoing the procedure. ◀

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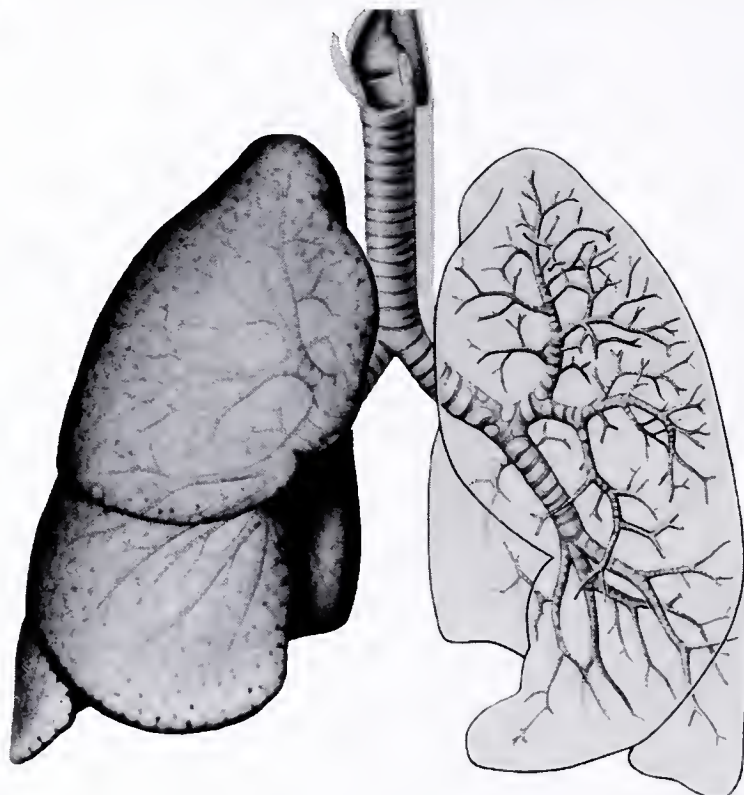
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Ceclor[®] (ceclor)

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Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β -hemolytic streptococci).

Contraindication:
Known allergy to cephalosporins.

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Administer cautiously to allergic patients. Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of non-susceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

- Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%.

- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme (rarely, Stevens-Johnson syndrome) or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypotonia, dizziness, and somnolence have been reported.

- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
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In a Community Hospital

Clinicopathologic Correlations of Eighty Nonpalpable Breast Lesions

By JOHN H. MUELLER, M.D., AND
GARRON M. LUKAS, M.D./CHAMPAIGN

Biopsy results of 80 nonpalpable mammographic breast lesions in 75 women over a 12-month period at a community hospital are examined and the use of mammography in the detection of breast cancer is discussed. Seventy-four of the patients underwent preoperative needle localization to ensure excision of the occult lesions. Seven biopsies (8.75%) were malignant and calcifications were present in 36% of all lesions.

Breast cancer is the most common cancer among women, affecting one out of every 11 women¹ (9.1%) at some point during their lives. In 1987, it was estimated that 130,000 new cases of invasive breast cancer were diagnosed in American women.² Prior to the advent of mammography, breast cancer was diagnosed when a woman noticed a breast mass, skin changes, an unusual nipple discharge, or breast pain, or when the same were discovered by her physician. Mammography now offers the woman and her physician the opportunity to detect clinically occult (nonpalpable) breast lesions. The average breast cancer requires approximately ten years to become palpable. Mammography can detect most of these lesions one to three years earlier.³ Appropriate biopsy of suspicious lesions enables detected malignancies to be treated earlier.

Diagnosis of occult malignancy is dependent upon several factors. First, the radiologist must have equipment specifically designed for mammography and must perform and interpret examinations frequently in order to make a confident diagnosis. Second, the surgeon and radiologist must communicate in order to unambiguously interpret the report and films. Furthermore, the surgeon must have the ability to localize the occult lesion to ensure its removal at surgery, and to remove as little of the normal breast tissue as possible. Finally, the specimen must be presented to the pathologist in a manner which will enable its comparison with the mammogram, if necessary, to correctly determine the histopathology of the lesion.

It is inherent in the diagnostic process that the majority of biopsies will be benign. However, proper

consultation between radiologist, surgeon, and pathologist will maximize the detection of malignancies, and thus benefit the patient.

Materials and Methods

The operating room records from January 1, 1986, to December 31, 1986 at our institution were reviewed. This survey yielded 197 breast biopsies for the 12-month period. After a review of the clinic charts, one visible skin lesion, three cases of gynecomastia, and 113 palpable breast lesions were excluded from our study. Other cases were excluded based on study criteria. These included patients in whom minimal abnormalities were detected on mammogram screening and palpated by a surgeon after an initial normal examination by the primary physician.

Of the final 80 mammographic lesions included in the study, 78 were biopsied by a group of three surgeons, and two were biopsied by a fourth surgeon. The preoperative and postoperative clinic records, all mammogram reports, and frozen and permanent section pathology reports for all 80 biopsies were reviewed.

The breast biopsies were scheduled as outpatient procedures. The patient reported to the clinic on the morning of surgery for mammographically-guided needle localization of the lesion under local anesthesia. A hooked wire was then inserted through the needle, repositioned as necessary, and the needle withdrawn. The wire was secured to the breast, and a confirmatory mammogram for wire placement was taken. Various needle localization procedures have been described in the literature.⁴⁻⁷ The patient was sent to the hospital with her mammograms and placed under general anesthesia. The wire and lesion were dissected out and sent to pathology for frozen section. If any doubt existed as to the removal of the lesion, the specimen could be mammogrammed. In one case the surgeon transected the wire at surgery. The remaining wire end and biopsy specimen were then removed under fluoroscopic guidance. In this series, none of the frozen section diagnoses of malignancy were followed immediately by definitive surgery. Patients were discharged after appropriate recovery, usually that same day.

In all cases, permanent sections were made and, if applicable, samples were taken for estrogen and progesterone receptor assays. The family was informed of the frozen section diagnosis immediately after surgery, and the results of the permanent sections were given to the patient as soon as they were available.

Results

Eighty nonpalpable breast lesions in 75 women aged 28-79 were biopsied. Malignant lesions were found in women between 49 and 75 years of age. (Table 1)

Fifty-one of the biopsies were done for mammographic lesions, 20 were done for the presence of suspicious calcifications, and nine had both a mammographic lesion and calcifications. (Table 2)

Seven of the 80 biopsies (8.75%) were malignant. Of the seven malignancies, three were intraductal carcinoma, one was infiltrating ductal carcinoma, and three had both infiltrating ductal and intraductal carcinoma. (Table 3) In five out of the

Table 1 Clinically Occult Mammographic Lesions: Distribution by Age			
Age	Benign	Malignant	Total
21-30	1	0	1
31-40	3	0	3
41-50	13	1	14
51-60	23	1	24
61-70	26	2	28
71-80	7	3	10
Total	73	7	80

seven malignancies (71.4%) the frozen section was correct. However, in two out of the seven (28.6%) the frozen section was false-negative (in both cases the pathologist reported fibrocystic disease on the frozen section, but intraductal carcinoma on permanent section).

Four of the seven women with malignant biopsies had follow-up modified radical mastectomies. One woman had a subcutaneous mastectomy and axillary node dissection, another had a partial mastectomy, and one elected to undergo no fur-

ther treatment after a second opinion (her surgeon had recommended mastectomy).

Seventy-three out of 80 (91.25%) biopsies were benign. The most frequent diagnosis was fibrocystic disease without epithelial proliferation (50.7%), followed by fibrocystic disease with epithelial proliferation (34.2%). (Table 4)

It is important to note that one of the frozen sections was false-positive, labeled as "infiltrating ductal carcinoma." The permanent section, after outside consultation,

Table 2 Reason for Biopsy of Nonpalpable Breast Lesions			
Mammographic Evidence	Benign	Malignant	Total
Lesion*	48	3	51
Calcifications	18	2	20
Lesion and Calcifications	7	2	9
Total	73	7	80
*Note: Includes any suspicious characteristic (increased density, change in architecture, speculations, etc.) other than calcifications.			

Table 3 Clinically Occult Mammographic Lesions: Histologic Findings in 7 Cancers		
Diagnosis	Number	Percent
Intraductal carcinoma	3	42.9
Infiltrating ductal carcinoma	1	14.3
Both	3	42.9

Table 4
Clinically Occult Mammary Lesions: Findings in
73 Benign Biopsies

Diagnosis (criteria from Schwartz, et al. ⁹)	Number	Percent
Fibrocystic disease without epithelial proliferation*	37	50.7
Fibrocystic disease, with epithelial proliferation**	25	34.2
Fibroadenoma	6	8.2
Foreign body reaction	3	4.1
Intramammary lymph nodes	1	1.4
Normal breast tissue	1	1.4
Total	73	100%

*Cysts, apocrine metaplasia, sclerosing adenosis, fibrous mastopathy
 **Papillomatosis, large terminal duct or lobular hyperplasia, florid adenosis (proliferative phase of sclerosing adenosis)

had a benign diagnosis of "florid epithelial proliferation and papillomatosis." Fortunately the patient and surgeon had elected to only undergo the biopsy on that date. Arguments for single vs. two-step biopsy and definitive treatment are recorded elsewhere,⁸ but it is prudent to emphasize that one must be confident with the frozen section diagnosis, as well as the preoperative and intraoperative clinical appearance of malignant lesions before proceeding with one-step procedures.

Discussion

Breast cancer is a significant cause of morbidity and mortality in

women. Risk is increased if a woman has a personal history of breast cancer or a first-degree relative with the disease.¹⁰ Mammography is the most widely used method to detect clinically occult breast lesions. With modern techniques, imagery has been greatly improved, and the radiation exposure is negligible. McLelland¹¹ extrapolated that the total radiation dose of modern bilateral two-view mammography (less than 1 rad) poses the same mortality risk as smoking three-fourths' of one cigarette or traveling sixty miles by car.

At this writing, the current recommendations^{12,13} of the American Cancer Society for the mammographic screening of asymptomatic women appear in Table 5. Unfortunately, screening mammography often tends to be underutilized. After reviewing four studies with a total of 3,677 patients, Howard¹⁴ concludes that "only about 15-20 percent of American women age 50 and older have ever had a mammogram and that a much smaller proportion are being examined with systemic regularity." Physicians must educate their patients about the incidence of breast carcinoma, and increase their efforts to refer asymptomatic women for screening.

In the present series, 8.75% of the mammographic lesions were malignant. This is consistent with other studies, which report the

rates between 8%¹⁵ and 32%.¹⁶ Since the goal of screening mammography is the detection of malignancies in asymptomatic women, an aggressive surgical approach of suspicious lesions is justified.

Reviewing the benign biopsies, the vast majority (84.9%) were diagnosed histopathologically as fibrocystic disease. This attests to the diagnostic difficulty this condition can represent for the mammographer. Homer¹⁷ addresses the importance of communication between the mammographer and surgeon to understand the exact meaning of the report. However, as stated previously, one must be willing to accept a large number of negative biopsies in order to detect occult mammary carcinomas.

Unlike other widely used cancer screening tests such as Papanicolaou's stain and the stool test for occult blood, mammographic screening is expensive. At this writing the median statewide cost of mammographic screening in Illinois is \$105.¹⁸ Reducing the expense of screening remains an important goal. However, considering the high incidence of breast cancer, patients should be encouraged to follow American Cancer Society (ACS) guidelines to the greatest extent possible. Hopefully, the costs will decrease as screening becomes more widespread.

Summary

Our experience with eighty non-palpable mammographic breast lesions was presented. Seven biopsies (8.75%) were malignant. The technique of preoperative needle localization was used to ensure removal of the intended specimen with a minimum of normal breast tissue. Screening mammography is seen as an effective tool for the diagnosis of breast cancer in asymptomatic women.

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Table 5
ACS Recommendations for
Screening Asymptomatic
Women

- ☐ Monthly breast self-examination beginning at age 20.
- ☐ Breast physical exam by physician every third year between 20 and 40, and yearly thereafter.
- ☐ Baseline mammogram between ages 35 and 40.
- ☐ Mammography every 1-2 years between ages 40 and 49.
- ☐ Yearly mammography after age 50.

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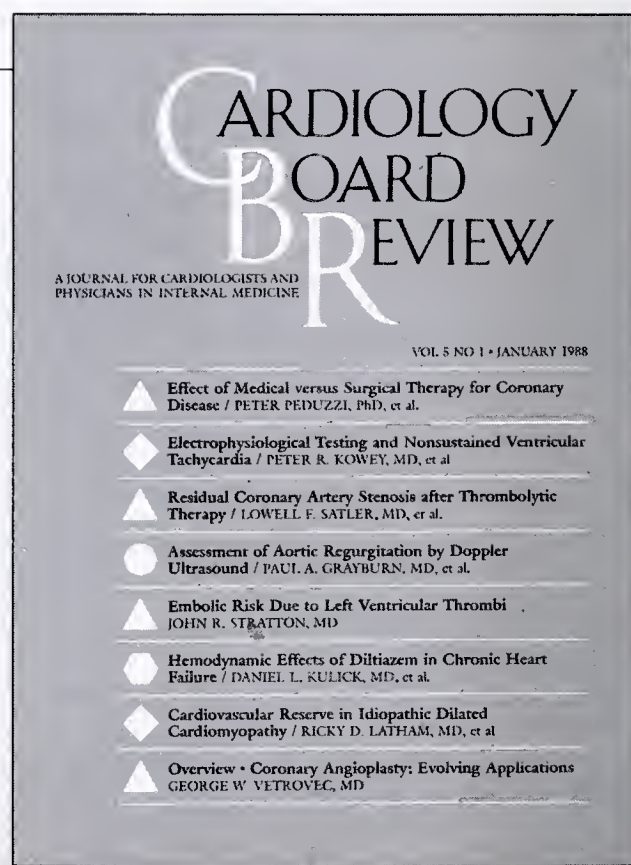
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A Pioneer in Mental Health Care **Dorothea Lynde Dix**

By FRANK B. NORBURY, M.D./JACKSONVILLE

Dorothea Lynde Dix was a nineteenth century pioneer in the mental health field. Her energy and strength of character engendered reforms in mental health care across the United States. Her work brought public bodies to recognize that the mentally ill were not criminals to be jailed, but patients to be given medical care and supervision.

Dorothea Lynde Dix was the founding spirit of the Jacksonville State Hospital, Illinois' first mental hospital, and more than 32 other psychiatric hospitals throughout the world. Many of these huge public institutions have disappeared or have been converted to smaller institutions for the care of the mentally retarded. This was the case in Jacksonville, where we now have the Jacksonville Developmental Center.

In phasing out state hospitals, we run the risk of losing sight of their historical purpose and the conditions which led to their founding. We might also lose sight of Dorothea Lynde Dix, who should be included among the most successful reformers of the nineteenth century. Her efforts established the concept that the mentally ill were the responsibility of the state. Her efforts took the mentally ill in



Dorothea Lynde Dix. Photo reprinted with permission of the Boston Athenaeum, Boston, Massachusetts.

America out of chains, jails, and almshouses. She engineered reforms to bring these patients under medical auspices, where they could receive humane care and specialized treatment.

Dorothea Dix's name was a household word in the latter part of the nineteenth century. Consulted by prominent politicians of her time, she was a personal friend of Presidents Fillmore, Pierce, Buchanan, and Lincoln and was granted a private audience with Pope Pius IX.

What was this woman really like? Several biographies have been written about her, but there are large gaps in our knowledge of her life. The original biography, authorized by her family, was written by the Reverend Francis Tiffany in 1891, four years after her death. But he had access only to those letters and papers which Miss Dix and her family made available. The last scholarly biography was written in 1937 and the last biography of any kind in 1975. Her papers remain in the Harvard Library.

A Maine Native

Dorothea Dix was born in 1802 in Hampden, Maine, a settlement on the Penobscot River near Bangor. The family occupied a cabin on land owned by her grandfather, Dr. Elijah Dix of Worcester and Boston. He had purchased 20,000

Her efforts took the mentally ill in America out of chains, jails and almshouses. She engineered reforms to bring these patients under medical auspices, where they could receive humane care and specialized treatment.

acres of Maine land from the endowment of Bowdoin College at \$1 per acre. Maine, at that time, was a territory of Massachusetts and definitely frontier land.

Dorothea's father, Joseph Dix, was sent out to act as a land agent for his father. He had married a woman 20 years older than himself while a student at Harvard, where, at that time, married students were not permitted. Joseph Dix had planned to be an establishment clergyman, but he never finished college and was never ordained.

Joseph nurtured his religious vocation by writing and distributing tracts in the wilderness and by occasional preaching. His wife, in her 40's when Dorothea, her first child, was born, was frequently ill. Dorothea later proclaimed that she "never knew a childhood," and was considered the strong one of the family, taking care of her mother, father and two younger brothers.

By 1812, the Embargo and the war with Britain had ruined trade on the Penobscot River. Joseph Dix took his family to Worcester, the original home of his parents. Dr. Elijah Dix had risen from a pharmacist's apprentice to become a prominent physician in Worcester. Deeply involved in land promotion, he was one of the developers of the Boston-Worcester Turnpike, selling off land along the way. The money he earned from this enabled him to live in luxury in Boston where he continued to invest in land. His wife, Dorothy Lynde, was of a prominent Worcester family.

Dorothea's grandfather seemed to take a liking to her and visits with him in Boston were among her few happy memories in an otherwise bleak childhood. He died while the family was still living in Maine, and his widow maintained an interest in the girl. At age 12, Dorothea left

Worcester and moved in with her grandmother, who preached and practiced a stern Bostonian Puritanism. After two years, she decided Dorothea should return to Worcester to live with her aunt.

A precocious child, Dorothea started teaching school at age 14. This continued until age 17, when Dorothea returned to Boston and established a school in her grandmother's home. She became engaged, but, for unknown reasons, never married.

Dorothea continued to teach and develop her mind. She became the friend and governess of the children of William Ellery Channing, one of the founders of Unitarianism. Channing preached a much warmer brand of religious and social concern than she had learned from her father and grandmother. She began to write and publish children's literature, including a forerunner of a children's encyclopedia called *Conversations on Common Things*. It went into several editions and brought in regular roy-

the Cambridge jail to teach Sunday school. There she found not only criminal prisoners, but insane women, who were kept because they had no other place to go.

Visiting other prisons and almshouses over the next two years, she continued to find insane people in chains, often in cages and unheated quarters. Some jailers believed that the insane could not feel the cold, making heat unnecessary. Violent screams and disturbed behavior forced the insane to be segregated from criminals, but not housed separately. After many of these visits, Dorothea Dix resolved to bring the problem to the attention of the state government, which she believed was responsible for the care of these people. She developed a plan and successfully used it many times.

The first step of her plan was to study and visit the jails, almshouses, and other places where the insane were kept. Next she prepared a "Memorial" to the legislature, and had it distributed and publicized. Finally she stayed discreetly near, but not in, the state capitol where she could lobby influential legislators for support of her proposed reforms. She first used this plan in 1843 in Massachusetts; she subsequently used it in over 20 other state legislatures, including Illinois' in 1847.

Dorothea was successful in Massachusetts and Rhode Island in declaring the mentally insane a state

Some jailers believed that the insane could not feel the cold, making heat unnecessary.

alties. This money, in addition to a large inheritance from her grandmother, would have enabled her to live out her life as a genteel maiden lady. But at age 38, her real life's work had yet to begin.

An Activist Emerges

On March 28, 1841, Dorothea's eyes were opened when she visited

responsibility. Funds were appropriated for semi-private ventures—use of public or charitable funds to enlarge or support care in already existing private hospitals. Word of Miss Dix's success in New England reached New Jersey, and she was urged to visit that state's jails and almshouses. New Jersey had no mental hospitals at all. Dorothea put her plan into action in 1845.

The result was the creation of a totally new institution, the Trenton State Hospital, which became the prototype of all state hospitals.

A Natural Administrator

Pennsylvania followed New Jersey and soon state governments all over the country sought her now-familiar plan. She became an authority on the architecture and site planning of mental hospitals throughout the country. One state after another followed her model with large, airy buildings, usually on a hill, featuring high ceilings and a central administrative area.

She also had a lot to say about how the hospitals would be run and who would run them. What is now the American Psychiatric Association was founded in 1845 and its members supported Miss Dix's efforts. Locally, the first three superintendents of the Jacksonville State Hospital—Drs. James Higgins, Andrew McFarland, and Henry F. Carriel—were all selected by her.

Jacksonville State Hospital's founding culminated the efforts of local citizens and legislators, who enlisted the help of Dorothea Dix. Edward Mead, a professor at the Illinois College Medical School in Jacksonville, studied some of the conditions for the care of the insane in Illinois and proposed a mental

Mental Health Policy Continues to Evolve

Dorothea Dix's work to create a public conscience with respect to care of the mentally ill engendered a proliferation of theories and approaches which continue to spark debate.

Miss Dix succeeded in planting the seed of what is now an accepted maxim in mental health care: society has an obligation to protect the rights of the mentally ill.

The Illinois Mental Health Code was rewritten in 1979 in order to address these issues. Late last year, Governor James R. Thompson appointed a special commission to review and revise the new code. Co-chairs of the committee are Cook County State's Attorney Richard M.

Daley and Donald Hallberg, president of Lutheran Social Services of Illinois.

The 23-member commission will seek public input and recommend revisions to the Illinois legislature. Pertinent issues are likely to include ambulatory commitment, voluntary vs. involuntary status, fitness to stand trial, the legal defense of insanity and use of restraints.

Physician members of the commission include Prakash Desai, Chicago, Thomas Minogue, Urbana, Hazel Mrazek, Maywood and Patrick Staunton, Park Ridge. The ISMS Council on Mental Health and Addiction will monitor the commission's work and offer assistance as needed.

Jacksonville State Hospital's founding culminated the efforts of local citizens and legislators, who enlisted the help of Dorothea Dix.

hospital in Jacksonville. A group of Jacksonville citizens, using Mead's findings, invited Miss Dix to come to Illinois, where she made first-hand visits to Illinois' almshouses and jails. In January 1847 she presented her findings in a Memorial to the Illinois legislature. She documents in detail the pitiful conditions in which the insane were kept in Illinois. Then she declared, "But

one effective remedy for these woes is presented; it can only be found in a well-established, skillfully conducted hospital. . . . Legislators of Illinois, upon your action on this question rest the peace and happiness, the usefulness and the lives (sic) of thousands of your fellow citizens . . . Respectfully submitted, D. L. Dix, Springfield, January 1847."

The legislature drew up a bill which met with her approval and which was enacted on March 1, 1847. The bill originally specified Peoria as the site of the hospital, but was amended to read Jacksonville. Thus, the Jacksonville State Hospital, Illinois' first mental hospital, was created.

Miss Dix remained interested in the Jacksonville Hospital, visiting it several times and sending books and supplies. Meanwhile, she continued to establish other hospitals on the eve of the Civil War.

When the War broke out, she volunteered her services to President Lincoln, who made her Chief Nurse of the Army. Despite her organizational ability, this was a job

for which she was unqualified and quite unsuccessful. She later wrote, "This is not the work I would have my life judged by."

Dorothea Dix's accomplishments ranged from prison reform, improvement of life-saving services in Nova Scotia, and the establishment of a Civil War Memorial at Hampton Roads, Virginia, to the provision of a fountain for thirsty horses in Boston's Custom House Square.

Despite her undoubted greatness and achievements, there are few memorials to Dorothea Lynde Dix. Furniture and memorabilia from

the early days of Jacksonville State Hospital, including furniture used by Miss Dix, have been widely scattered. Some material recently has been assembled and will be displayed in a nineteenth century building at the Illinois School for the Deaf in Jacksonville in honor of Dorothea Lynde Dix.

Frank B. Norbury, M.D., is a board certified internist affiliated with Passavant Area Hospital in Jacksonville, where he also maintains a private practice. A past president of the

Illinois Society of Internal Medicine, Dr. Norbury is a downstate Illinois governor for the American College of Physicians. A member of the American Society of Internal Medicine and a fellow of the American College of Physicians, Dr. Norbury, is a third generation physician practicing in Jacksonville. His grandfather began a practice at Jacksonville State Hospital in 1888.

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A complete bibliography for "Dorothea Lynde Dix: A Pioneer in Mental Health" may be obtained by writing the *Illinois Medical Journal* at Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602.

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Main Office Address: 1341 Houghton Road, Bolingbrook, Illinois 60139
Phone: (312) 759-1000
Degrees: D.D.
Specialty: Family Practice
Sex: Male
Internship at: New Britain Hospital, Middletown
Current Hospital Affiliation: City of Hope Hospital

SURGE

Name: Steven Holtzman
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Main Office Address: 1020 Glen Flora, Waukegan, Illinois 60087
Phone: (312) 244-8020
Degrees: M.D., Ph.D.
Specialty: General and Vascular Surgery
Board Certifications: Surgery
Sex: Male
Internship at: University of Illinois Medical Center
Residency at: University of Illinois Medical Center
Current Hospital Affiliation: Victory Hospital, Waukegan

Name: Kenneth
Practice Name: Kenneth Chesson
Main Office Address: 1752 W. Algonquin Road, Hoffman Estates, Illinois 60139
Phone: (312) 885-7777
Degrees: M.D.
Specialty: Gastroenterology
Board Certifications: Gastroenterology
Sex: Male
Internship at: University of Illinois Medical Center
Residency at: University of Illinois Medical Center
Current Hospital Affiliation: Victory Hospital, Waukegan

Name: Edward H. Malters
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Main Office Address: 131 Summit, Elmhurst, Illinois 60120
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Degrees: M.D.
Specialty: Family Practice
Sex: Male
Internship at: University of Illinois Medical Center
Residency at: University of Illinois Medical Center
Current Hospital Affiliation: Victory Hospital, Waukegan

Correspondence from an Illinois Frontier Physician

Go West Young Man!

By ORLANDO M. BRYAN, M.D.

(CONTRIBUTED BY JOHN W. OVITZ, JR., M.D./SYCAMORE)

Orlando M. Bryan, M. D., was born in 1823 in Fairfield, Herkimer County, New York, and was the son of Dr. and Mrs. M. L. Bryan. He attended medical school at Fairfield, studied under Dr. Sweet, and received his M.D. degree from the University of New York City in 1844. In 1846 he came to DeKalb County and began practice in Sycamore, Illinois. He subsequently served as a brigade surgeon in the Civil War where he reached the rank of Brevet Colonel, and was the medical director of the division of New Mexico at one time. He was active in the growth of Sycamore, and died February 25, 1892. In 1849 he married Jane Leslie Voothers of Brooklyn, New York. He started practicing medicine in Sycamore 100 years before his great-grandson, John W. Ovitz, Jr., M. D., who continues to practice there today.

The following is a letter that Dr. Bryan wrote to his friend, Dr. Griswold, on January 26, 1847.

Sycamore
January 26, 1847

Gaylord F. Griswold, M.D.
Newport
Herkimer County, New York

Friend Griswold:

Received your line a week ago. Should have answered it before but being too late for the mail of that week am obliged to wait until the present date.

You commenced your letter by urging me to consider your situation—*out of business*. Not knowing

where to find any, etc. Your situation I have considered and feel that I can appreciate it perfectly. You are aware, *my situation in Fairfield for many months was similar to your own*. That was the unhappiest period of my existence. My days were spent in *gloomy forebodings of the future, meditating upon the difficulties of obtaining and retaining business*. Nights, my mind was frequently harassed with dismal dreams of *failures in business, persecution, hunger, and starvation*. Thus passed many an unhappy day, how often would I think while in those gloomy moods, that if I could only be

placed in a pleasant, lucrative and respectable practice, my greatest Earthly desire would be realized.

And I recollect at the commencement of my studies I would look forward to my examinations and the receipt of my diploma, at being of more importance than *all things* else, that when that was gained, the battle was won, the course through life thence would be easy and without a care. But I find that if we are ever so fortunate as to gain these great objects, still, there is *something* wanting, and there is yet a vacuum, that can *never* be filled.

Before going much farther I will

answer those questions in your letter as correctly as possible. It will not be in my *power* to answer them all. You say you are coming West early in the Spring—come, of course, when you please—But if I was coming West, to obtain a location for the practice of medicine and know what I *now* know I should by *all means* manage it so as to be *here* at the time the sickness commences, with its greatest severity, it is then that our best practitioners want young partners, for they are there during the whole season drove with business, but in the winter and spring, the business is limited and they dislike to take partners, it is also a much better time to get into business for yourself, the time to be here in my opinion is about the first of July. I arrived here about the last of August, commenced my partnership the 10th of September, was much too *late*; lost 2 to 3 hundred dollars by it. Dr. Page done in the month of August alone \$400. Dr. Whiting wrote me that he had charged from the first of July to the middle of November, 4½ months, \$1200, but you know that has been an unusually good season for Drs. You are but a little more liable, if any, to be sick by coming in the sickly season than if you come before or after. You must *run the risk of being sick*, anyway, if come West, and *no one can tell you* whether *you will* or *will not*, that is the only objection to the West. You may enjoy much better health here than East, and you may not do as good. There are enough good openings, some on the Rock River, some near here, and many on the Mississippi River. You should come *prepared to look about*, thinking you would do well to visit Dr. Whiting, should be very happy to see you myself and would do all I could for you. I had a good offer to go in partnership with a Dr. Whitney of Belvidere, he has yet no partner. I preferred Sycamore as there is less competition. If you come West with the idea of remaining, bring what you will want with you, your books, instruments, medicines, and so forth, as you can leave them stored in Chicago with but little expense, while you are looking about, and so when you are settled have them sent at anytime to you. I found my med-

icine books, instruments, and so forth of great benefit to me in obtaining business. Dr. Whiting was the man that first seriously hinted to me, the prosperity of trying the West. It was then a new idea, but being as I have said before out of business and in, as it were, a despairing mood, I grasped at the first straw that presented itself and easily made preparations for a departure. Dr. Whiting shall always have my *sincerest thanks* for encouraging me to do something for myself, but more particularly for urging me to try the *West*. My anticipations in regard to the West have been more than realized, the county is more beautiful, people more intelligent and hospitable, and by far more *sickness*, and of course the practice is *decidedly lucrative*. The first fortnight of my partnership with Page I averaged alone, (he being sick with bilious fever) \$9.50 per day. It was when there was the most sickness. This you need not mention to anyone—it was a very good *start for a beginner*; better than to lay in old Fairfield and gradually *decompose*. I will now mention some of the advantages of Western practice. First, our epidemics: Ague, chillfever, Congestive fever, and Bilious fevers, come mostly when the roads are *beautiful* and the weather delightful, differing from the East where we have to work our passage by shoveling *snowdrifts*. Second, the *pay* is nearly *all* good. Nearly all are landholders, and the poorest raise some *wheat*. We receive but very *little* cash down, but we take Notes immediately after dismissing a patient, and they are most all good in a year's time. Third, there is some pleasure in the practice from the fact that we can generally help our patient *immediately*. We seldom visit a common case more than once. You know Quinine is a medicine of *great* power in our Western summer diseases. In regard to the pay, I told you it is not cash but with notes you can pay your board bill. Can purchase a good horse on *time* in the country for \$50, and for \$30 cash in Chicago, at auction. For my horse, a *beautiful one*, I paid \$65, for my sulky \$50, for fine harness, saddle and bridle \$22. You can get board and lodging in the country for

\$1.25 and in the Villages for about \$2. I pay \$2.50 per week for my board and lodging and horse stabling, find my own grain, oats and corn in the ear are 12½¢ per bushel. I board at the Hotel and never had better board. You had better, by all means, send to New York for at least \$20.00 worth of Quinine, and two pounds of Calomel, and as much blue mass. You will save half on expensive medicines by so doing. We have used nine bottles of Quinine since I have been here. As it respects a drugstore, it would be firstrate, if the individual had capital to do a credit business. Cash business would do nothing. You had better bring what instruments and books you will need for you can buy them cheaper East, and a better variety, and you will have to pay cash for them here, I would lay out but little for instruments, as there is but very little use for them here. We have had but an inch or two of snow, and until a week past it has been quite warm, it is now very cold, thermometer ranging for a few days past 12° below Zero. My medicine case answered an admirable purpose, use one of the other *large boxes* for Quinine. You speak of Michigan, there are undoubtedly good openings there, but I don't like the state as well as Illinois. You are misinformed in regard to the health at Galena, it has been very sickly there, and in fact *throughout* the Western Country and never has been known more so. The society at Galena and the lead mines about, is without doubt some of it very bad, as it is a general resort for *black legs*. Around *here* the society is mostly of young married people and that is *excellent*.

The diseases we have to treat here in the winter are very similar to our Eastern Winter complaints. With the exception of *Bilious* Pneumonia, that is a very severe disease here, have just returned from a ride of 13 miles, found my patient severely attacked with Bilious Pneumonia and acute inflammation of the kidneys. We have had cases of croup, mumps, tonsillitis, rheumatism, pleurisy, inflammation of the brain, and bowels, and in fact all the inflammatory diseases of the East. I wonder where Dr. Sweet calculates to go, give him my respects.

There is but little necessity for a man to be married here in order to get business, the people have become accustomed to employing unmarried men. Most of the physicians in these parts are unmarried men; but it is very easy for a man to obtain a *good* wife if he should chance to want one, even in this country. Selby had been but a short time out of jail when I was there, he was regaining some of his old practice, and I should not be much surprised if he should outlive it and still do well there. You ask what it cost me to get where I am, that would be no criterion for you, as it cost me about double what it would have if I had not made so many stops. If you please, you can get

here for a trifle, take a packetboat from Little Falls to Buffalo, and a steerage passage from thence to Chicago, or you may go on a (*Pнопеллас*), in that way it would not cost you over \$5 and it would not as much next season from Buffalo to Chicago. From Chicago the traveling is very cheaply staged all over the states. As you might purchase a horse in Chicago and in doing traveling on horseback. As the propriety of your coming West, I can say nothing, nor give no advice, but can say this, that if you could be insured of health, you could do by *far* better here than you can East, and you may stand as good a chance as anyone for that. Remember me to Walter and tell him I should be very

happy to see him with you at Sycamore. My particular respects to Mrs. Chassill and family. If you see Ma or Martha, tell them I am still in perfect health. Should be glad to hear from you any time.

Yours truly,

O. M. Bryan

John W. Ovitz, Jr., M.D., is the great-grandson of Orlando M. Bryan, M.D. Board certified in family practice, Dr. Ovitz is affiliated with the Sycamore Hospital, Sycamore. He has been an ISMS delegate from DeKalb County since 1968.

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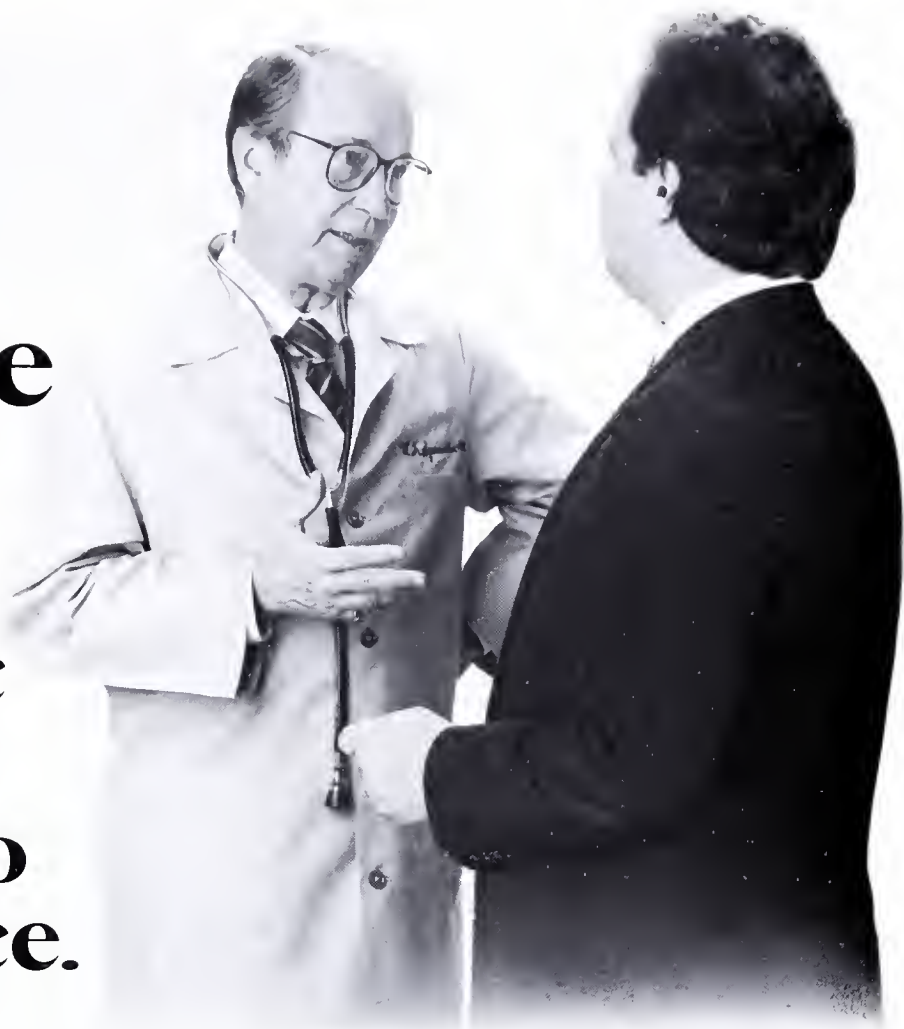
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Our Focus is on You

BY SHERRY BETSILL (MRS. WESLEY), ISMSA PRESIDENT

The following address was given by Mrs. Betsill upon her installation as president of the ISMSA on April 22, 1988.

As we celebrate our sixtieth anniversary, I want to take a few moments to reflect on our past. In 1928 when this organization was formed, its primary function was "to assist in establishing a closer feeling and a better understanding between the medical profession and the general public; and further, through the auxiliary, leverage can be brought to bear to secure legislation that will be beneficial to public welfare and against the handicapping laws now being urged." I'm not sure which handicapping laws they were working against in 1928, but I do know that today we are faced with proposed legislation that may drastically change the practice of medicine. Mandatory Medicare assignment, malpractice, and now possibly euthanasia are important legislative issues. (The Hemlock Society in California is trying to get a referendum on the November ballot making euthanasia a legal option.)

As the practices of our physician spouses change, our attitudes to these changes must keep pace. We as auxiliaries have a responsibility to be as informed as we possibly can be about the current issues facing the medical profession today.

As a state organization we try diligently to educate our members. This is done in a variety of ways: district meetings are held throughout the state; mini-workshops that deal with problems indigenous to that area are presented; a statewide Fall Conference is held; and we publish a newsletter four times a year.

In addition, as members of the American Medical Association Auxiliary, leadership training conferences are held twice a year for future leaders of county auxiliaries. *FACETS*, a magazine that informs members about changes in the medical profession and the many health concerns facing them, is published six times a year. Many additional

publications are available free to auxiliaries from the AMAA's excellent media resource department.

It is hard for me to believe that in just twelve years we will enter the 21st century. As an organization, we should be proud of our past accomplishments and look forward to the challenges that lie ahead.

Forty years ago polio was a dreaded disease. Today it is a disease of the past. Today we are confronted with the Acquired Immune Deficiency Syndrome (AIDS). Let us hope that in forty years this, too, also be a disease of the past.

Every day our children are facing decisions that will effect their lives. Drug abuse, suicide, pregnancy, the use of alcohol, smoking—these are some of the health problems facing young people today. Education is the key for combating these issues.

My theme for this year is, "Auxiliary—The Focus is on You." In the health projects area we will contin-

ue our focus on the adolescent health initiative. Three years ago we focused on teenage suicide by presenting a seminar dealing with this devastating topic. Several of our county auxiliaries are now involved with teenage suicide programs in their local school districts. This past year we presented an adolescent health seminar. We videotaped this seminar and are making the tapes available to any of our county auxiliaries. This year we will focus on drug and alcohol abuse.

Although young people are our future, we must not forget the fastest growing segment of our population, the elderly. Those of us who are reaching the point when our children are self-sufficient may be faced with the care of aging parents. This past year we purchased a video, "Sit and Be Fit," that can be used in the care of nursing home patients. One of these was given to each of our county auxiliaries. This year we will present a program on dealing with a person with Alzheimer's disease.

We will also focus on membership. Our membership has been dwindling for the past several years and we need to examine the reasons behind this decline. Our potential membership is drastically changing; it is projected that by the year 2000, 50% of medical school graduates will be women. Male spouses must be encouraged to join this organization. Female spouses are re-entering the work force or are continuing to work; they must be encouraged to join our organization. Graduates from medical schools outside of the United States are ever-increasing in numbers; we must encourage their spouses to join.

The Auxiliary is highly visible in communities throughout our state promoting health projects, sponsoring education programs in their schools, or lobbying legislators. My challenge to you is to recruit one new member to our organization. If you can accomplish this, we will have strength in numbers and will be able to accomplish any task. ◀

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Hiring a Medical Assistant

By *LESA B. HILDEBRAND, Ed.M., CMA-C*

The medical assisting profession is expected to increase significantly throughout the next decade. Sources are available to enable physicians to carefully choose competent employees.

One excellent source for a physician to utilize in seeking a competent employee is the American Association of Medical Assistants. This professional organization, with national headquarters in Chicago, can provide information about medical assistants, put you in touch with local people who can help advertise your position, and explain the requirements needed to graduate from a CAHEA-accredited (Committee on Allied Health Education and Accreditation) medical assisting program.

In addition, physician-employers may phone any of the four Illinois program coordinators and advertise the position at their institution: Lesa Hildebrand, Ed.M., CMA-C, Triton College (312) 456-0300, extension 293 or 438; Vera Davis, R.N., CMA, Harper College (312) 397-3000; Rose Hall, RN, CMA-AC, Belleville Area College (618) 235-2700; and Judith Marshall, MT, CMA-C, Robert Morse

(217) 357-2121.

Once you have inquiries from interested graduates of the above programs or other applicants, it is important to investigate the extent of the medical assistant's training and relevant work experience.

Sample questions you might consider would be:

1. Is this applicant a certified medical assistant (CMA), or planning to become one?
2. Is this medical assistant active in the American Association of Medical Assistants and keeping abreast of the continuing education offered to both members and non-members?
3. Is this individual qualified to perform both clinical and administrative tasks?
4. Does this applicant hold a current first aid and CPR certificate?
5. If the applicant is a CAHEA-accredited program graduate, where did she/he extern, and what skills were utilized at these facilities?
6. Does this individual appear to be a personable employee who will foster the goodwill of

patients?

The aforementioned program coordinators would be able to furnish you with a current salary range received by their graduates. An optimal time to secure an employee would be the end of May, when most of the accredited programs conclude. In addition, all of these accredited medical assisting programs provide an externship for students. You may be interested in offering your facility as an externship site. This would enable a student to utilize skills gained from the program and, upon graduation, become an excellent employee who is acclimated to your working environment.

For further information regarding the Illinois Society of Medical Assistants and/or the hiring of a medical assistant, please contact: Cheryl Hutchison, CMA, president, 53 Lockhaven, Granite City, IL 62040, or public relations co-chairpersons: Lesa Hildebrand, Ed.M., CMA-C, Triton College, 2000 Fifth Avenue, River Grove, IL 60171, or Lucille Perce, CMA-C, 22W 384 Teakwood Drive, Glen Ellyn, IL 60137.

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MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Chronic exposure to sunlight may result in a premalignant lesion of the lower lip, actinic cheilitis. Many treatments have been used and the authors suggest the best may be the CO₂ laser under local anesthesia. It is associated with remarkably low morbidity, especially in comparison with vermilionectomy. This is because vaporization is limited to diseased tissues, the mucosal epithelium, and the very superficial dermis. (Stanley, R., Roenigk, R. *Mayo Clin Proc* 63:3, 230-5, 1988)

Complications and the interval between complication and cardiac pacemaker implantation were evaluated in 100 consecutive patients in 1985. Two patients each experienced pneumothorax and ventricular lead dislodgements, one had atrial lead dislodgement and one had cardiac tamponade. Within 24 to 72 hours, one experienced tachycardia, five had atrial failure, two had pacemaker tachycardia, and one experienced ventricular oversensing. Ambulatory pacemaker implantation may be possible in a select subgroup of patients; a 24-hour stay appears safer with subsequent outpatient follow-up. (Hayes, D., *et al.*, *Mayo Clin Proc* 63:3, 236-240, 1988)

Statistical analyses for breast cancer screening in women between ages 40-49 revealed a general incidence of 128/10,000 chance of having breast cancer within that 10-year span, and of these, 82/10,000 would die of breast cancer. Adding mammograms to annual physicals would reduce the probability of death to approximately 60 in 10,000, or about a 26% reduction. The risk of radiation-induced cancer from mammography for 10 years is 1:10,000 and the risk of surgery for noncancerous lesion is 1:10. If 25% of women in this age group were screened annually, 1,569 late stage breast cancers would be prevented by the year 2000. The tests and treatment would approximate \$408 million. Treatment costs would decrease by approximately \$6 million, leaving a net cost in the year 2000 of about \$402 million. (Eddy, D. *et al.*, *JAMA* 259:10, 1512-19, 1988.)

Amitriptyline appears a most useful adjunct for treatment of nondirected agitation in traumatic brain injury. Approximately 30% of patients recovering from traumatic brain injury exhibit agitation. Forty-three males and 15 female patients with a recent severe brain injury were admitted for rehabilitation in a conventionally-structured program. Twenty of these patients had severe agitation impeding rehabilitation. Within seven days of initiation of amitriptyline, 12 of 17 patients with severe posttraumatic amnesia had a dramatic decrease in agitation. (Mysiow, W., *et al.*: *Am J Phys Med Rehabil* 67:1, 29-33, 1988)

Subarachnoid hemorrhages were induced in monkeys; widespread vasospasm was observed on angiography 5-6 days later. Diltiazem was given 48 hours prior to the experimental subarachnoid hemorrhage. *In vitro* examinations of the cerebral arteries in this treated group compared to the untreated group showed only minimal functional changes in the vascular smooth muscle cells, lesser arterial wall stiffness and contractility. Diltiazem appeared to act on the cerebrovascular smooth muscles in lower concentrations than on smooth muscles in other vascular beds. Interfering with calcium entry through receptor-operated and potential sensitive channels may protect against calcium-induced cell death. (Bevan, R., *et al.*: *Stroke* 19:1, 73-79 1988)

The rehabilitation outcome in strokes was greatly influenced by the frequently-associated cardiac pathologies. One-hundred-thirty-two patients with a first thrombotic or embolic stroke showed an incidence of 61 cases (46%) of coronary artery disease, and 16 of these had congestive heart failure. Patients with coronary artery disease did least well at rolling, moving in bed, transferring from wheelchair to bed, and in walking. Patients with congestive heart failure experienced three times as many cardiac complications, and were adversely affected in overall function, mobility and the potential for rehabilitation. (Roth, E., *et al.*: *Stroke* 19:1, 42-47, 1988)

Glyburide and NPH insulin were compared in patients with non-insulin dependent diabetes mellitus. Similar improvements were noted in fasting blood glucose levels, hemoglobin A_{1C} concentrations, and frequency of mild hypoglycemia. The triglyceride and cholesterol levels were decreased on both regimens, but the insulin-treated group showed higher levels of high density lipoprotein cholesterol and a higher ratio of high-density lipoprotein to total cholesterol. (Nathan, D., *et al.*: *Ann Int Med* 108:3, 334-340, 1988)

Long term effects on blood cholesterol levels of diet, niacin, and/or probucol were evaluated on 37 patients with hypercholesterolemia and severe atherosclerosis. Dieters showed an average drop in their cholesterol levels from 336mg/dL to 279, but this level could not be maintained. The addition of niacin reduced the cholesterol levels to 240mg/dL, but was maintained in only seven of 37 patients. Nineteen of 37 patients on diet, niacin, and probucol achieved blood cholesterol levels of 201, which were maintained by 11 of the 19 patients. (Cohen, L., Morgan, J.: *J of Fam Pract* 26:2, 145-150, 1988) ◀

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Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

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Protection against angina attacks^{1,5,7-9}

The predictable efficacy of Cardizem in stable exertional* and vasospastic angina allows patients to do more.

A decrease in myocardial oxygen demand

Resulting from a lowered heart rate-blood pressure product.⁵

Compatible with other antianginals⁶⁺

Safe in angina with coexisting hypertension, COPD, asthma, or PVD^{1,3,5,6}

*CARDIZEM® (diltiazem HCl) is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents

[†]See Warnings and Precautions

Please see brief summary of prescribing information on the next page.

60 mg **GREATER**
DOSAGE
90 mg **FLEXIBILITY**
120 mg



CARDIZEM[®] ANTIANGINAL PROTECTION diltiazem HCl/Marion PLUS SAFETY

Usual maintenance dosage range: 180-360 mg/day

BRIEF SUMMARY Professional Use Information

CARDIZEM[®]
(diltiazem HCl)
30 mg, 60 mg, 90 mg, and 120 mg Tablets

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, (3) patients with hypotension (less than 90 mm Hg systolic), and (4) patients who have demonstrated hypersensitivity to the drug.

WARNINGS

- 1. Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
- 2. Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
- 3. Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
- 4. Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, LDH, SGPT, and other phenomena consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Dermatological events (see ADVERSE REACTIONS section) may be transient and may disappear despite continued use of CARDIZEM. However, skin eruptions progressing to erythema multiforme and/or exfoliative dermatitis have also been infrequently reported. Should a dermatologic reaction persist, the drug should be discontinued.

Drug interaction. Due to the potential for additive effects, caution and careful titration are warranted in patients receiving CARDIZEM concomitantly with any agents known to affect cardiac contractility and/or conduction. (See WARNINGS.)

Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

As with all drugs, care should be exercised when treating patients with multiple medications. CARDIZEM undergoes bio-

transformation by cytochrome P-450 mixed function oxidase. Coadministration of CARDIZEM with other agents which follow the same route of biotransformation may result in the competitive inhibition of metabolism. Dosages of similarly metabolized drugs, particularly those of low therapeutic ratio or in patients with renal and/or hepatic impairment, may require adjustment when starting or stopping concomitantly administered CARDIZEM to maintain optimum therapeutic blood levels.

Beta-blockers: Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities.

Administration of CARDIZEM (diltiazem hydrochloride) concomitantly with propranolol in five normal volunteers resulted in increased propranolol levels in all subjects and bioavailability of propranolol was increased approximately 50%. If combination therapy is initiated or withdrawn in conjunction with propranolol, an adjustment in the propranolol dose may be warranted. (See WARNINGS.)

Cimetidine: A study in six healthy volunteers has shown a significant increase in peak diltiazem plasma levels (58%) and area-under-the-curve (53%) after a one-week course of cimetidine at 1,200 mg per day and diltiazem 60 mg per day. Ranitidine produced smaller, nonsignificant increases. The effect may be mediated by cimetidine's known inhibition of hepatic cytochrome P-450, the enzyme system probably responsible for the first-pass metabolism of diltiazem. Patients currently receiving diltiazem therapy should be carefully monitored for a change in pharmacological effect when initiating and discontinuing therapy with cimetidine. An adjustment in the diltiazem dose may be warranted.

Digitalis: Administration of CARDIZEM with digoxin in 24 healthy male subjects increased plasma digoxin concentrations approximately 20%. Another investigator found no increase in digoxin levels in 12 patients with coronary artery disease. Since there have been conflicting results regarding the effect of digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing CARDIZEM therapy to avoid possible over- or under-digitalization. (See WARNINGS.)

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in *in vitro* bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater

than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

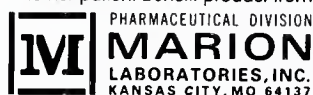
Cardiovascular:	Angina, arrhythmia, AV block (first degree), AV block (second or third degree—see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.
Nervous System:	Amnesia, depression, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.
Gastrointestinal:	Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGPT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.
Dermatologic:	Petechiae, pruritus, photosensitivity, urticaria.
Other:	Amblyopia, CPK elevation, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarthral pain, polyuria, sexual difficulties.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. Issued 6/87

See complete Professional Use Information before prescribing.

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Diagnosis: Urachal cyst with focal adenocarcinoma

The calcified cyst wall is seen on the plain radiograph (Figure 1) and the bladder is compressed by the cyst on the cystogram (Figure 2). The cyst was filled with mucoid material, which appeared more dense than water on the CT study. (Figure 3) The cyst was resected. It had a thin wall, but a focal area of thickening proved to be adenocarcinoma.

Embryology

The exact embryologic origin of the urachus is not clear.¹⁻⁴ The earliest development of the fetal excretory structure is the allantois, which extends from the yolk sac through the umbilical cord to the placenta. The yolk sac eventually forms the cloaca, which divides into the bladder ventrally and into the rectum from the dorsal part. Some maintain that the allantois obliterates completely and is entirely extraembryonic and that the urachus forms from the ventral aspect of the bladder. Others believe that the allantois is partly intraembryonic, persisting as the urachus.^{1,3}

The urachus elongates during fetal life and is completely obliterated at birth. In the adult, a fibrous band remains and extends from the anterior wall of the bladder, just below the apex, 10-12cm distally to the umbilicus.

The urachus is a musculo-fibrous tube composed of an inner layer of transitional cell epithelium, a connective tissue layer of blood and lymph vessels, and an outer muscular layer which is contiguous inferiorly with the detrusor muscle.² It is divided into a long supraventricular portion and a short intramural portion.⁵ The intramural portion is again subdivided into intramural and intramucosal parts.⁵

The urachus is situated in the space of Retzius, a triangle formed by the umbilicus as the apex, the laterals by umbilical ligaments and below by the dome of the bladder.^{2,5} It lies between the transversalis fascia and the parietal peritoneum,⁵ surrounded by layers of the umbilicovesical fascia.¹ These fascial planes limit the spread of a urachal neoplasm and infection.¹ Failure or incomplete closure of the urachus after birth results in urachal anomalies.

Symptoms and Signs

Patent Urachus

Total failure of closure of the urachal lumen results in a communication between the umbilicus and the bladder. Urine leak from the umbilicus is the most reliable sign of the problem.¹ The umbilicus may present as a tumor-like projection in about half of the cases.² Some patients have associated obstructive uropathy; obstruction is considered to be the cause of a patent urachus in some patients.² Patent urachus has

been reported in 50% of cases of prune belly syndrome,^{2,3} and is the most common form of urachal anomaly. It usually presents soon after birth.^{1,2}

Urachal Cyst

This anomaly develops when the urachus is closed at both ends with cyst formation in the middle. This retention cyst usually develops in the lower third of the urachus and contains mucous secretions.^{1,2} The cysts often go undetected until infection occurs, or until a tumor develops into the bladder.^{1-3,6} Lower abdominal pain and signs of infection may be the only indications of an infected urachal cyst and diagnosis may be difficult if there is no obvious abdominal mass.^{2,7} In untreated cases the abscess can drain from the umbilicus or into the bladder. Cases of intraperitoneal rupture of infected cysts have been reported.^{1,2}

Urachal carcinoma is a serious complication arising from the cyst, and accounts for 0.01% of all malignancies and 0.34% of bladder carcinomas.^{8,9} Of the reported patients, 80% were men, mostly between 40-70 years of age.^{5,10} Histologically, the majority of cases are mucinous adenocarcinomas.^{1,4,5,8,11} Since the bladder and rectum are derived from a common structure, the cloaca, embryonic inclusion of intestinal type mucosa with goblet cells may explain the apparent change in cell type.^{4,10} Others believe that metaplasia from this transitional cell epithelium lining in the urachus gives rise to adenocarcinoma.⁴ Most often patients present with hematuria.^{4,8,10} The passage of mucus material in the urine occurs in 10% of patients.⁸

Release of mucus while applying suprapubic pressure has been observed during cystoscopy and is considered pathognomonic for an adenocarcinoma of the urachus.¹⁰ The disease usually spreads by local invasion and metastases are primarily to the regional nodes, lung and bones.^{4,10}

Urachal Sinus

The urachus communicates with the umbilicus but the end at the bladder is closed. A draining urachal sinus is commonly associated with lower abdominal tenderness and fever.² The umbilicus may show signs of inflammation with development of granulation tissue.

Vesicourachal Diverticulum

The urachus communicates with the bladder but the end at the umbilicus is closed. It is believed that some cases of vesicourachal diverticulum are related to lower urinary tract obstruction.² It is usually discovered during a cystogram or cystoscopy.² A large diverticu-

lum may produce mechanical pressure on the ureter and intestine.⁷

Radiology

Patent Urachus and Urachal Sinus

Fistulography^{1,2} and sinography using iodinated material will delineate the anomalies. Voiding cystography¹ is also important to detect lower urinary tract obstruction.

Vesicourachal Diverticulum

Excretory urography and cystourethrography³ can reveal the presence and the size of the diverticulum. Some patients have a diverticulum secondary to bladder outlet obstruction which will also be demonstrated by the cystourethrogram.

Urachal Cyst

Conventional radiography has been of limited value in the diagnosis of urachal cysts.⁸ Plain radiographs may reveal calcification in some cases.^{5,8} A calcified supravescical mass, in conjunction with passage of mucus in the urine, is considered to be highly suggestive of urachal carcinoma.⁸

Urography may show deformity of the bladder outline and lateral displacement of the ureter.^{2,5,8} The close proximity of the urachus to the abdominal wall makes it ideally suited for ultrasound,^{5-7,13} which can accurately define the extent and nature of the anomalies.

An infected thick-walled urachus may simulate carcinoma. Fine needle biopsy and cystologic examination will clarify the diagnosis. The extent of solid, invasive urachal carcinomas are best demonstrated by computed tomography (CT)^{2,7,8} or magnetic resonance.

The differential diagnosis of a urachal cyst includes a bladder diverticulum, umbilical hernia, or ovarian cyst.² An infected cyst may be difficult to differentiate from acute appendicitis, cystitis or diverticulitis.^{2,7}

Treatment

Because of the possibility of malignant degeneration and the high recurrence rate, radical excision of ura-

chal cysts is recommended.³ Carcinoma of the urachus is treated with radical cystectomy unless there is an early focal carcinoma.⁴ The prognosis is poor, with five year survival rates from 6.5% to 15%.^{8,11} Radiation treatment and chemotherapy showed unfavorable results.^{4,8}

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

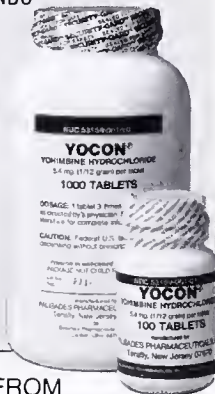
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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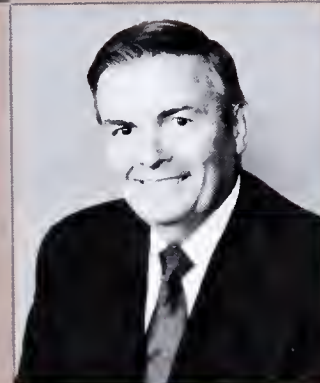
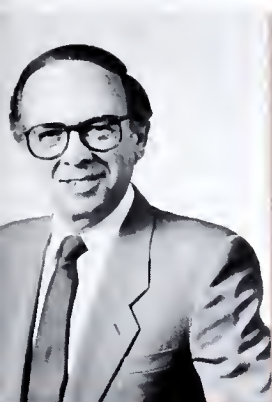
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Official Journal of the Illinois State Medical Society

Volume 173, Number 6, June 1988

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Clearing the Air



Physicians and patients are increasingly militant about the rights of nonsmokers and the need for public education on the health hazards of tobacco use.

The Surgeon General has declared that the nicotine in tobacco is as addictive as cocaine or heroin. He has told the Congress that 300,000 Americans die from tobacco-related causes each year. Koop likes to present that statistic in context, showing that alcohol (alone or in combination with other drugs) accounts for 129,000 deaths annually, opiates for another 4,000 and cocaine for 2,000 more. Those are serious numbers. They reinforce the fact that tobacco is a very serious drug.

Smoking was a major theme at this year's April 22-23 House of Delegates meeting. Our delegates reaffirmed and expanded upon the Society's longstanding opposition to cigarette smoking.

House action was both specific and practical. Our delegates sought to restrict smoking in public buildings, restaurants, hospitals, public health facilities and public transportation vehicles. They demanded that the Illinois Delegation to the American Medical Association seek national legislation ending federal tobacco farming subsidies. And

they short-circuited at least one political end-run by directing that the government should instead provide a temporary subsidy to help tobacco farmers convert to other crops.

The Chicago City Council very recently passed an ordinance—long supported by the Chicago Medical Society—to restrict smoking in public buildings. I hope that our state legislature will soon get the message and follow suit.

Physicians can be highly effective patient advocates in this area. We can raise the issues and educate the policymakers. It's the kind of volunteer work we should all find the time to do. Our 1988 ISMS Physician Public Service Award winner was recognized, in large part, for his public education efforts on the dangers of cigarettes. Luke Burdard, M.D., has used everything

from poster contests to student rallies to teach our patients that smoking is not an innocent pastime. He has worked with great success to build a coalition spearheading support for the Illinois Clean Indoor Air Act.

Illinois is one of only eight states in the nation with no restrictions on smoking in public places. But despite years of active support from ISMS and a broad coalition of public health advocates, the Illinois Clean Indoor Air Act fell short by one vote six weeks ago. Some people are very confused.

Physicians have a responsibility in this context. It's time that our society got serious about this drug. We can make that happen by doing what we do best: bringing the straight health facts to our patients and our communities. We need to clear the air on smoking. ◀

A handwritten signature in black ink, reading "Harry A. Springer". The signature is fluid and cursive, with a large, stylized "S" at the end.

Harry A. Springer, M.D.
President

IN ANTIHYPERTENSIVE THERAPY **PERFORMANCE**



***Maintains
physical
performance***



***Maintains
mental
performance***



***Maintains
sexual
performance***



COUNTS...

Maintains physical, mental, and sexual performance

- Alpha₁ blockers maintain normal hemodynamics during rest and exercise¹
- Seldom causes depression, confusion, loss of alertness²
- Impotence is rare—incidence equal to placebo³

Significantly decreases total cholesterol^{*4}

Effective in younger and older patients, blacks as well as whites¹

Side effects generally were mild and transient. Dizziness and asthenia were most common. Others reported significantly more frequently than with placebo were nasal congestion, peripheral edema, somnolence, nausea, palpitations, and blurred vision. Incidence of syncope (1.0%) was not significantly different from placebo.

* HYTRIN is not indicated for the treatment of hyperlipidemia.

HYTRIN[®] 1mg,
2mg,
5mg
tablets
(terazosin HCl) **ONCE-A-DAY**
ONE PRICE

The first once-a-day alpha₁ blocker



advancing cardiovascular care

Please see adjacent page for Brief Summary of prescribing information.

HYTRIN®
(terazosin hydrochloride tablets)

Brief Summary

CLINICAL PHARMACOLOGY: Pharmacodynamics: Clinical studies of terazosin used in once-a-day (majority) and b.i.d regimens with total doses usually in the range of 5-20mg/day, in patients with mild or moderate hypertension. Because terazosin, like all alpha antagonists, can cause large falls in blood pressure after the first dose or first few doses, the initial dose was 1mg in virtually all studies, with subsequent titration to a specified fixed dose or titration to a specified blood pressure end point.

Blood pressure responses were measured at the end of the dosing interval (usually 24 hrs.) and effects were shown to persist throughout the interval, with usual supine responses 5-10mmHg systolic and 3.5-8mmHg diastolic greater than placebo. The responses in the standing position tended to be somewhat larger, although this was not true in all studies. The magnitude of blood pressure responses was similar to prazosin and less than hydrochlorothiazide (in a single study). In measurements 24 hrs. after dosing, heart rate was unchanged.

Limited measurements of peak response (2-3 hrs. after dosing) during chronic terazosin administration indicate that it is more than twice the trough (24 hr.) response, suggesting some attenuation of response at 24 hrs., presumably due to a fall in blood terazosin concentrations at the end of the dose interval. This explanation is not established with certainty and is not consistent with the similarity of blood pressure response to once-a-day and b.i.d dosing. With the absence of an observed dose response relationship over a range of 5-20mg, i.e., if blood concentrations fall to the point of providing less than full effect at 24 hrs., a shorter dosing interval or larger dose should lead to increased response. Measure blood pressure (BP) at the end of the dose interval; if response is not satisfactory, patients may be tried on a larger dose or b.i.d regimen. The latter should be considered if side effects, such as dizziness, palpitations, or orthostatic complaints, are seen within a few hours after dosing.

The greater BP effect associated with peak plasma concentrations (first few hours after dosing) appears somewhat more position-dependent (greater in the erect position) than the effect of terazosin at 24 hrs. In the erect position there is a 6-10 bpm increase in heart rate in the first few hours after dosing. During the first 3 hrs. after dosing 12.5% of patients had a systolic pressure fall of 30mmHg or more from supine to standing, or standing systolic pressure below 90mmHg with a fall of at least 20mmHg, compared to 4% of a placebo group.

INDICATIONS AND USAGE: Indicated for the treatment of hypertension

CONTRAINDICATIONS: None known

WARNINGS: Syncope and "first-dose" Effect: Terazosin, like other alpha-adrenergic blocking agents, can cause marked hypotension, especially postural hypotension, and syncope with the first dose or first few doses. A similar effect may occur if therapy is interrupted for more than a few doses. Syncope has been reported with other alpha-adrenergic blocking agents in association with rapid dosage increases or introduction of another antihypertensive drug. Syncope may be due to an excessive postural hypotensive effect, although occasionally the syncopal episode has been preceded by severe supraventricular tachycardia with heart rates of 120-160 bpm.

To decrease the likelihood of syncope or excessive hypotension, always initiate treatment with a 1mg dose at bedtime. The 2mg and 5mg tablets are not indicated as initial therapy. Increase dosage slowly, and add additional antihypertensive agents with caution. Caution patients to avoid situations where injury could result if syncope occurs during initiation of therapy.

In early studies, where increasing single doses up to 7.5mg were given at 3 day intervals, tolerance to the first dose phenomenon did not necessarily develop and the "first dose" effect was observed at all doses. Syncopal episodes occurred in 3 of 14 subjects given doses of 2.5, 5, and 7.5mg, which are higher than the recommended initial dose. Severe orthostatic hypotension (BP 50/0mmHg) was seen in two others and dizziness, tachycardia, and light headedness occurred in most subjects. These adverse effects all occurred within 90 min. of dosing.

In multiple dose clinical trials involving nearly 2000 patients, syncope was reported in about 1% of patients, in no case severe or prolonged, and was not necessarily associated with early doses.

If syncope occurs, place patient in recumbent position and treat supportively. There is evidence that the orthostatic effect of terazosin is greater, even in chronic use, shortly after dosing.

PRECAUTIONS: General. Orthostatic Hypotension: While syncope is the most severe orthostatic effect of terazosin, other symptoms of lowered BP, such as dizziness, lightheadedness and palpitations, are more common, occurring in 28% of patients in clinical trials. Patients with occupations in which such events represent potential problems should be treated with particular caution.

Information for Patients: Make aware of possibility of syncopal and orthostatic symptoms, especially at initiation of therapy, and to avoid driving or hazardous tasks for 12 hrs. after the first dose, after a dosage increase, and after interruption of therapy when treatment is resumed. Caution to avoid situations where injury could result should syncope occur during initial therapy. Advise to sit or lie down when symptoms of lowered BP occur and to rise carefully from a sitting or lying position. Bothersome dizziness, lightheadedness, or palpitations should be reported to physician.

Tell patients that drowsiness or somnolence can occur, requiring caution in people who must drive or operate heavy machinery.

Laboratory Tests: Small but statistically significant decreases in hematocrit, hemoglobin, WBC, total protein and albumin were observed in clinical trials. The magnitude of decreases did not worsen with time. These findings suggest the possibility of hemodilution.

Drug Interactions: In controlled trials, terazosin was added to diuretics, and several beta-adrenergic blockers, no unexpected interactions were observed. Terazosin has been used concomitantly without interaction in at least 50 patients on the following: 1) analgesic/anti-inflammatory (acetaminophen, aspirin, codeine, bupropion, mefenamic acid), 2) antibiotics (erythromycin, trimethoprim and sulfamethoxazole), 3) anticholinergic/sympathomimetics (phenylephrine HCl, phenylpropanolamine HCl, pseudoephedrine HCl), 4) antigout (allopurinol), 5) antihistamines (chlorpheniramine), 6) cardiovascular agents (atenolol, hydrochlorothiazide, methylclothiazide, propranolol), 7) corticosteroids, 8) gastrointestinal agents (antacids), 9) hypoglycemics; 10) sedatives and tranquilizers (diazepam).

Carcinogenesis, Mutagenesis, Impairment of Fertility: HYTRIN was devoid of mutagenic potential when evaluated *in vivo* and *in vitro*.

HYTRIN, administered in feed to rats at doses of 8, 40, and 250mg/kg/day for 2 yrs., was associated with a statistically significant increase in benign adrenal medullary tumors of male rats exposed to the 250mg/kg dose. This dose is 695 X max. recommended human dose (20mg/55kg). Female rats were unaffected. HYTRIN was not oncogenic in mice when administered in feed for 2 yrs. at a maximum tolerated dose of 32mg/kg/day.

The absence of mutagenicity in a battery of tests, of tumorigenicity of any cell type in the mouse carcinogenicity assay, of increased total tumor incidence in either species, and of proliferative adrenal lesions in female rats, suggests a male rat species-specific event. Numerous other diverse pharmaceutical and chemical compounds have been associated with these tumors in male rats without supporting evidence for carcinogenicity in man.

Effects on fertility were assessed in a standard fertility/reproductive performance study in which male and female rats were administered oral doses of 8, 30, and 120mg/kg/day. Four of 20 male rats given 30mg/kg and 5 of 19 male rats given 120mg/kg failed to sire a litter. Testicular weights and morphology were unaffected. Vaginal smears at 30 and 120mg/kg/day appeared to contain less sperm than smears from control matings and good correlation was reported between sperm count and subsequent pregnancy.

Oral use for 1 or 2 yrs. elicited a statistically significant increase in testicular atrophy in rats exposed to 40 and 250mg/kg/day, but not in rats exposed to 8mg/kg/day (> 20 X max. recommended human dose). Testicular atrophy was observed in dogs dosed with 300mg/kg/day (> 800 X max. recommended human dose) for 3 months but not after 1 yr. when dosed with 20mg/kg/day. This lesion has also been seen with Minipress®.

Pregnancy: Teratogenic effects: Pregnancy Category C. There are no adequate and well controlled studies in pregnant women and the safety of terazosin in pregnancy has not been established. HYTRIN is not recommended during pregnancy unless potential benefit justifies potential risk to mother and fetus.

Reproductive effects: In a peri- and post-natal development study in rats, significantly more pups died in the group dosed with 120mg/kg/day (> 300 X max. recommended human dose) than in the control group during the 3-week post-partum period.

Nursing Mothers: It is not known whether terazosin is excreted in breast milk, therefore, exercise caution when administering terazosin to a nursing woman.

Pediatric Use: Safety and effectiveness have not been determined.

ADVERSE REACTIONS: The prevalence of adverse reactions has been ascertained from 14 placebo-controlled studies conducted primarily in the US. The studies involved once a day administration of terazosin as monotherapy or in combination with other antihypertensive agents, at doses ranging from 1 to 40mg. All adverse events reported during these studies were recorded as adverse reactions. Adverse events where the prevalence rate in the terazosin group was at least 5%, where the prevalence rate for the terazosin group was at least 2% and was greater than the prevalence rate for the placebo group, or where the reaction is of particular interest are summarized below. Only asthenia, blurred vision, dizziness, nasal congestion, nausea, peripheral edema, palpitations and somnolence were significantly (p<0.05) more common in patients receiving terazosin than in patients receiving placebo. Other events include [%TERAZOSIN-%PLACEBO]: asthenia (1.3%-4.3%), back pain (2.4%-1.2%), blurred vision (1.6%-0%), depression (0.3%-0.2%), dizziness (19.3%-7.5%), dyspnea (3.1%-2.4%), edema (0.9%-0.6%), headache (16.2%-15.8%), impotence (1.2%-1.4%), libido decreased (0.6%-0.2%), nasal congestion (5.9%-3.4%), nausea (4.4%-1.4%), nervousness (2.3%-1.8%), pain-extremities (3.5%-3%), palpitations (4.3%-1.2%), paresthesia (2.9%-1.4%), peripheral edema (5.5%-2.4%), postural hypotension (1.3%-0.4%), sinusitis (2.6%-1.4%), somnolence (5.4%-2.6%), tachycardia (1.9%-1.2%), weight gain (0.5%-0.2%).

Adverse reactions were usually mild or moderate in intensity but sometimes were serious enough to interrupt treatment. Adverse reactions that were most bothersome as judged by being reported as reasons for discontinuation of therapy by at least 0.5% of the terazosin group and being reported more often than in the placebo group [%TERAZOSIN-%PLACEBO] are: asthenia (1.6%-0%), blurred vision (0.6%-0%), dizziness (3.1%-0.4%), dyspnea (0.9%-0.6%), headache (1.3%-1%), nasal congestion (0.6%-0%), nausea (0.8%-0%), palpitations (1.4%-0.2%), paresthesia (0.8%-0.2%), peripheral edema (0.6%-0%), postural hypotension (0.5%-0%), somnolence (0.6%-0.2%), syncope (0.2%-0.2%), tachycardia (0.6%-0%).

Additional adverse reactions have been reported, but these are not distinguishable from symptoms that might have occurred in the absence of exposure to terazosin. The following additional adverse reactions were reported by at least 1% of 1987 patients who received terazosin in clinical studies or during marketing experience: abdominal pain, abnormal vision, anxiety, arrhythmia, arthralgia, arthritis, bronchitis, chest pain, cold symptoms, conjunctivitis, constipation, diarrhea, dry mouth, dyspepsia, epistaxis, facial edema, fever, flatulence, flu symptoms, gout, increased cough, insomnia, joint disorder, myalgia, neck pain, pharyngitis, pruritus, rash, rhinitis, shoulder pain, sweating, tinnitus, urinary frequency, urinary tract infection, vasodilation, vomiting.

DOSE AND ADMINISTRATION: Dose and dose interval (12 or 24 hrs.) should be adjusted according to BP response.

Initial Dose: 1mg at bedtime. Observe the initial dosing regimen strictly to minimize potential for severe hypotensive effects.

Subsequent Doses: Slowly increase dose to achieve desired BP response. Usual dose range is 1mg to 5mg once a day. Some patients may benefit from doses up to 20mg/day. Doses over 20mg do not appear to provide further BP effect. Doses over 40mg have not been studied. Monitor BP at the end of dosing interval to assure control is maintained. It may be helpful to measure BP 2-3 hrs. after dosing to see if maximum and minimum responses are similar, and to evaluate symptoms which can result from excessive hypotensive response. If response is substantially diminished at 24 hrs. consider an increased dose or b.i.d. regimen. If administration is discontinued for several days or longer, reinstitute therapy using initial dosing regimen. In clinical trials, except for the initial dose, the dose was given in the morning.

Use With Other Drugs: Caution should be observed when terazosin is administered concomitantly with other antihypertensive agents (e.g., calcium antagonists) to avoid the possibility of significant hypotension. When adding a diuretic or other antihypertensive agent, dosage reduction and retitration may be necessary.

August, 1987 Abbott Health Care Products, Inc. North Chicago, IL 60064 8023854/R

References: 1. Dzau VJ: Evolution of the clinical management of hypertension; Emerging role of "specific" vasodilators as initial therapy. *Am J Med* 1987;82(suppl 1A):36-43. 2. Data on file, Abbott Pharmaceuticals. 3. Mersey JH: Alpha₁-blockade in hypertension management. *Prim Cardiol* 1987;13:93-101. 4. Hytrin: Product Information Abbott Pharmaceuticals.

OBITUARIES

***Bloch, Winston N.,** Quincy, died April 2, 1988, at the age of 45. Dr. Bloch was a 1968 graduate of the University of Kentucky Medical School.

***Bourque, Joseph N.,** Moline, died September 23, 1987, at the age of 67. Dr. Bourque was a 1949 graduate of the University of Health Sciences/Chicago Medical School.

****Goldenberg, Max M.,** Belleville, died April 6, 1988, at the age of 74. Dr. Goldenberg was a 1935 graduate of Washington University School of Medicine, St. Louis.

****Gustafson, Joseph G.,** Moline, died April 9, 1988, at the age of 80. Dr. Gustafson was a 1935 graduate of the University of Illinois College of Medicine, Chicago.

Murphy, Cornelius E., Wilmette, died December 7, 1987, at the age of 82. Dr. Murphy was a 1933 graduate of Loyola University Stritch School of Medicine, Maywood.

****Rubin, Harold X.,** Chicago, died April 13, 1988, at the age of 84. Dr. Rubin was a 1932 graduate of the University of Illinois College of Medicine, Chicago.

**Indicates ISMS member*

***Indicates member of ISMS Fifty Year Club*

Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

Contraindications: There are no known contraindications to the use of 'Tagamet'.

Precautions: While a weak antiandrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlorthalidone, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.),

demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly un-

likely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only), and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

Liquid: 300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).

Injection:

Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage® Vials: 300 mg./2 ml. in single-dose, ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl (brand of cimetidine hydrochloride) Injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

* ADD-Vantage® is a trademark of Abbott Laboratories.

BRS-TG-L73B

Date of Issuance Apr. 1987

SK&F LAB CO.

Cidra, P.R. 00639

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First to Heal

You'll both feel good about it.

RESULTS

ABSTRACTS OF ACTIONS

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and

are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

April 21-24, 1988

Westin O'Hare Hotel

BEAUTIFUL BABIES CAMPAIGN

The Beautiful Babies campaign is being sponsored by WBBM Television and the University of Chicago Hospital to encourage prospective mothers to obtain prenatal care, and the Society has been asked to give their formal endorsement to the project. Representatives of the campaign have reported on the impact of the Washington, D.C. campaign which occurred last year and serves as the model for the Chicago area project. Public health clinic prenatal visits, previously on the decline in the Washington, D.C. area, are up 21% since the beginning of the campaign. Governor Thompson has offered an endorsement.

The Board endorsed pursuing active physician and staff involvement in the "Beautiful Babies" campaign, including placement of physicians on key committees.

The Board also authorized the investigation of means for ISMS to serve as a visible promoter of the project, recognizing budget constraints, including such avenues as notifying pertinent ISMS membership, featuring the campaign in *IMJ* and other means of gaining visibility for the program in the medical community.

DRUGS AND THERAPEUTICS

The Board approved that the following drug products be recommended for inclusion in the IDPA Drug Manual: Enkaid (Encainide); Microx (Metazone); Prinivil (Lisinopril); Rowasa (Mesalamine); and Zestril (Lisinopril).

The Board also recommended that IDPA not include miscellaneous vitamin supplements in its Drug Manual.

After reconsideration of an adverse Committee recommendation, the Board recommended that IDPA not include the drug product Xanax in the IDPA Drug Manual.

The Board further recommended that IDPA delete the drug product Tonocard from the Drug Manual.

FEDERAL HEALTH CARE QUALITY IMPROVEMENT ACT

Congress enacted and the President signed into law in 1986 the Health Care Quality Improvement Act (S 1744). Under this Act, several provisions are in

place, two of which are of particular importance to the medical profession. One is creation of a national register on disciplinary actions under which all adverse peer review or credentialing actions must be reported, as well as any indemnification in a malpractice action. The mechanisms for reporting were recently identified in the *Federal Register* as a proposed rule. The second issue deals with the national clearinghouse itself, for which no contract has been given as yet. Additionally, Congress has provided no funding at this time. Since there are several elements which are questioned in the proposed rule, the Board authorized the Chairman to submit comments to the Department of Health and Human Services prior to the deadline date of May 22.

MEDICARE HMO REVIEW

Subsequent to a competitive bid process last year, HCFA awarded a contract for review of services provided to Illinois Medicare beneficiaries enrolled in HMOs to Quality Quest, a Minnesota based organization. Crescent Counties Foundation for Medical Care has informed ISMS that HCFA has now directed Blue Cross-Blue Shield of Illinois, the Part A Medicare fiscal intermediary, to release data tapes to Quality Quest concerning HMO admissions. Although Quality Quest should have access to HMO data because of its review contract with HCFA, the Board believes that it is inappropriate for Quality Quest to obtain physician and patient specific data about other hospital admissions. A particular concern is the use of such data by Quality Quest as an outside entity. The Board agreed to protest, to the appropriate entities, the release of data, other than specific Medicare HMO admission data, to Quality Quest.

OTHER ACTIONS

In addressing various other issues, the Board:

- Noted the resignation of Dr. Robert C. Hamilton, Third District Trustee, effective April 23, 1988.
- Reviewed in executive session the issue of mandatory assignment and possible amendments to the

(Continued on page 380)



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THE INFORMED PHYSICIAN

THE INFORMED PHYSICIAN KNOWS WHAT QUESTIONS TO ASK, WHAT ISSUES TO RESOLVE AND WHEN TO CONSULT AN ATTORNEY, ACCOUNTANT OR ACTUARY WHEN CONSIDERING CONTRACTING WITH ALTERNATIVE DELIVERY SYSTEMS. THE ISMS OFFICE OF CONTRACTUAL SERVICES PRESENTS "THE INFORMED PHYSICIAN" AS AN EDUCATIONAL TOOL DESIGNED TO ILLUSTRATE, THROUGH REAL-LIFE SITUATIONS, THE SIGNIFICANT LEGAL AND ECONOMIC ISSUES WHICH FREQUENTLY ACCOMPANY CONTRACTS FOR THE DELIVERY OF HEALTH CARE, AND TO ALERT PHYSICIANS OF THE WAYS IN WHICH CONTRACTS MAY AFFECT THE PRACTICE OF MEDICINE.

A Look at Indemnification

Plain Talk About Who Pays

BY JUDÉE GALLAGHER, J.D./CHICAGO

Why would a multispecialty medical group pay the bills of an HMO? Because its HMO contract contained an indemnification—a promise to be responsible for someone else's liabilities. In this case the bills total over a half million dollars. They include a judgment against the HMO, plus attorney fees and defense costs in a medical malpractice suit. The HMO, the treating physician's group and the treating physician were named in that suit.

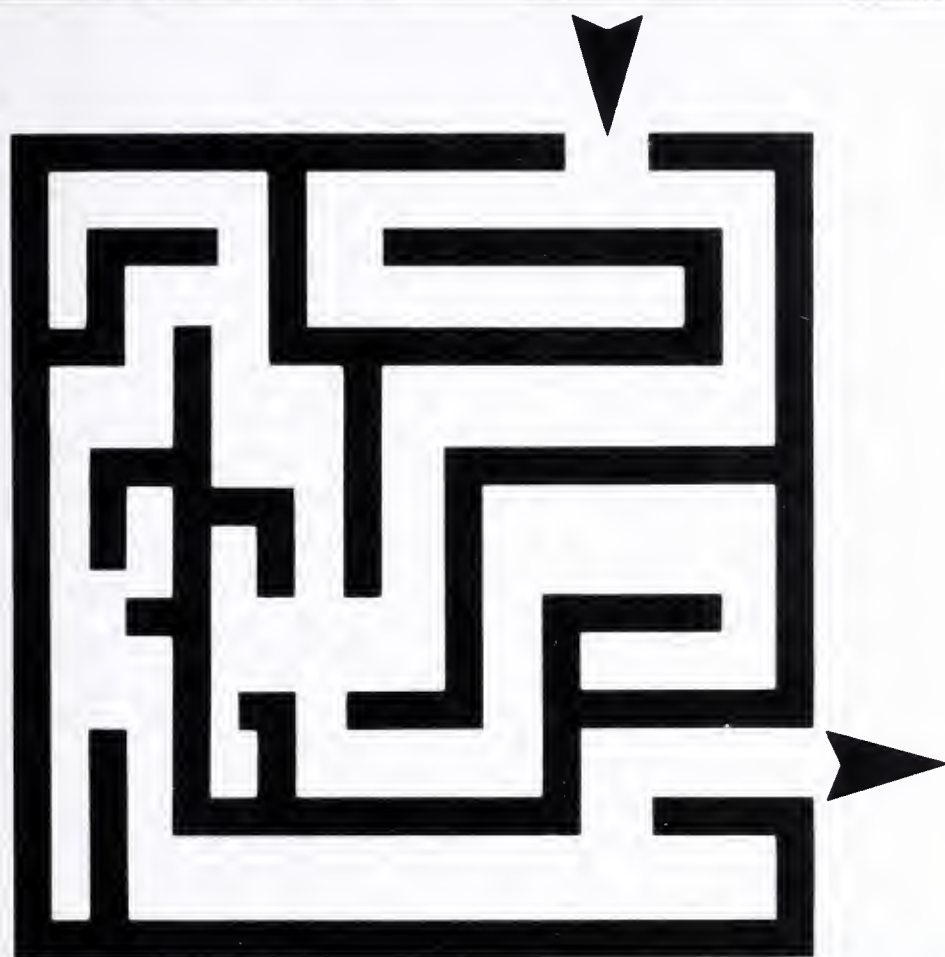
Will the group's insurance provide coverage for the HMO bills? No. Most professional liability insurance policies, including the Illinois State Medical Inter-Insurance Exchange Policy, specifically *exclude* from coverage liabilities which you (or your corporation or partnership) assume because of a contract. And that is what an indemnification clause is—an agreement to assume someone else's liability. Professional liability insurance companies generally cov-

er you for your actions or omissions which could comprise medical malpractice, but not for the liability of others that you have assumed by signing a contract. If you sign a contract with an indemnification clause, your own personal assets are at risk.

Are indemnification clauses easy to spot? Sometimes. If you see the word "indemnify" or the phrase "indemnify and hold harmless" your contract contains an indemnification. Sometimes an indemnification looks something like this: "The Physician shall indemnify and hold harmless the ABC HMO from and against any liability arising under the contract." But it could be much longer. And not all indemnifications actually use the word "indemnify," although the informed reader can usually recognize one. Look for all statements regarding your responsibilities. Consider this one: "Physician is *responsible for* all liabilities, claims, and damages including

attorney fees arising from medical care." If both you and your contractor—an HMO, PPO, or IPA—are sued for negligence on account of "medical care," you would be *responsible for* payment of the other party's attorney fees and the cost of defense. If there were a judgment against the other party, you, arguably, could be held *responsible for* paying it. These costs are out of pocket. Malpractice insurance would not cover them.

Many contracts containing provisions whereby the physician indemnifies the HMO from any claims arising from medical care also provide that the HMO indemnifies the physician against claims arising out of administrative services. But this does not solve the problem with physician indemnification. Many HMOs make medical necessity decisions and effect "medical care" through their utilization management systems. Even if it were possible (and it is not) for the physician



CONTRACT REVIEWS

HMO
PPO
IPA

Before
you
sign,
negotiate

Before
you
negotiate,
review

The ISMS Office of Contractual Services reviews HMO, PPO and IPA contracts for members. The cost is \$100 per review.

Reviews do not constitute legal advice. They provide a working document which highlights key issues, such as malpractice coverage, reimbursement concerns and practice limitations.

For further information contact:

ISMS Office of Contractual Services
Twenty North Michigan Ave., Suite #700
Chicago, Illinois 60602

(312) 782-1654 or (800) 782-ISMS

and the HMO to separate "medical care" and "administrative" functions into neat categories, there is no reason to believe that the plaintiff will obey the categorizations and only sue physicians for "medical care." Once you become a co-defendant with an HMO for liabilities created by "medical care," your indemnification kicks in and you are liable for any judgment against the HMO. Even if there is no judgment against it, you remain liable for its attorney fees and expenses.

Because you're an informed physician who recognizes the complex issues involved in contracts for the delivery of medical care, your first step was to send the contract offered you or your IPA to the

ISMS Office of Contractual Services. As a *members only service*, the office provides objective comments on any HMO, PPO or IPA contract for the nominal fee of \$100. Contract reviews highlight "standard of care," compensation and insurance issues, and pinpoint ambiguous language and inconsistent or contradictory provisions.

The review is a basic tool to help understand the contract. It's a good first step, but never a substitute for reading of the contract itself. It's not legal advice and the office cannot recommend that any contract is good or bad and should or shouldn't be signed. Each physician (or physician's corporation or partnership) must make that decision.

The informed physician's personal attorney and accountant must be consulted before decisions are made.

Your attorney has undoubtedly explained that when you are considering an Individual Participation Agreement with an HMO, PPO or IPA you may not band together with other physicians to negotiate the contract collectively, because that violates antitrust laws. You can, however, individually negotiate your own contract by yourself or with your personal attorney or financial advisor.

Judee Gallagher, J.D., is a Chicago private practice attorney retained by the ISMS Office of Contractual Services since 1985.

Dx: recurrent herpes labialis

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Lip Balm
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as needed*

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OTC. See P.D.R. for information. For samples to make your own clinical evaluation, write: CAMPBELL LABORATORIES, INC., P.O. BOX 812-MD, FDR STATION, NEW YORK, N.Y. 10150

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Superior tissue penetration and duration of action

DURICEF[®]

(CEFADROXIL)

... the oral cephalosporin with
once- or twice-a-day dosing

*May not correlate with clinical results.

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• Evansville, Indiana 47721 U.S.A. J-V23

For Brief Summary, please see following page.

DURICEF® (CEFADROXIL)

Penetration plus Duration
in Oral Cephalosporin Therapy

INDICATIONS: DURICEF (cefadroxil) is indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms: Urinary tract infections caused by *E. coli*, *P. mirabilis*, and *Klebsiella* species. Skin and skin structure infections caused by staphylococci and/or streptococci. Pharyngitis and tonsillitis caused by Group A beta-hemolytic streptococci. (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. DURICEF is generally effective in the eradication of streptococci from the nasopharynx; however, substantial data establishing the efficacy of DURICEF in the subsequent prevention of rheumatic fever are not available at present.)

Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

CONTRAINDICATIONS: DURICEF is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

WARNING: IN PENICILLIN-ALLERGIC PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF PENICILLINS AND CEPHALOSPORINS, AND THERE ARE INSTANCES OF PATIENTS WHO HAVE HAD REACTIONS TO BOTH DRUGS (INCLUDING FATAL ANAPHYLAXIS AFTER PARENTERAL USE).

Any patient who has demonstrated a history of some form of allergy, particularly to drugs, should receive antibiotics cautiously and then only when absolutely necessary. No exception should be made with regard to DURICEF (cefadroxil). **Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use.** Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Moderate to severe cases should be managed with fluid, electrolyte and protein supplementation as indicated. When the colitis is not relieved by drug discontinuance or when it is severe, oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should also be considered.

PRECAUTIONS: Patients should be followed carefully so that any side-effects or unusual manifestations of drug idiosyncrasy may be detected. If a hypersensitivity reaction occurs, the drug should be discontinued and the patient treated with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

DURICEF (cefadroxil) should be used with caution in the presence of markedly impaired renal function (creatinine clearance rate of less than 50 ml/min/1.73M²). (See Dosage and Administration section of Prescribing Information.) In patients with known or suspected renal impairment, careful clinical observation and appropriate laboratory studies should be made prior to and during therapy.

Prolonged use of DURICEF may result in the overgrowth of non-susceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug. DURICEF should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to 11 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cefadroxil. There are, however, no adequate and well controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Caution should be exercised when cefadroxil is administered to a nursing mother.

ADVERSE REACTIONS: Gastrointestinal—Symptoms of pseudomembranous colitis can appear during antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity—Allergies (in the form of rash, urticaria, and angioedema) have been observed. These reactions usually subsided upon discontinuation of the drug.

Other reactions have included genital pruritus, genital moniliasis, vaginitis, and moderate transient neutropenia.

Before prescribing or administering, see package insert

BRISTOL LABORATORIES **Mead Johnson**
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Bristol-Myers U.S. Pharmaceutical and Nutritional Group
Evansville, Indiana 47721 USA

MEDICAL STUDENT SECTION IN ACTION

A Reassessment of Education

By STEVE CALLAGHAN, NORTHWESTERN UNIVERSITY MEDICAL SCHOOL

In recent years, ideas about education and the ways in which people learn have been changing. Medical education has been criticized for emphasis on rote memory at the expense of practical understanding. But, any such criticism should be evaluated in the context of medical education's unique goals.

Changes in education have come on several fronts. One is a trend toward home schooling, as more and more parents become disillusioned with today's public school systems. Another is the integration of state-of-the-art technology into the learning process.

There is also an increasing recognition of the value of alternative forms of education.

Medical education currently provides some flexibility in its programs. There are six-year medical school programs, with non-core curricula in the form of optional seminars. It is easy for students to take a year off between their second and third years of medical school and obtain clerkships for appropriate educational experience. Some medical schools no longer require the MCAT exam, while others allow the student to continue into the clinical clerkship without passing initial board examinations. Most schools do not require attendance at every class, allowing students to choose the modality which works best for them. Most medical schools have a learning resource center. There, available materials enhance learning by the use of sight, sound and touch, all at the student's pace.

To improve medical education,

students should be taught to work with some of the "expert systems" and other tools of our day. It is important to recognize that an in-depth command of all areas of medicine is not achievable or, in fact, desirable.

Alternative types of education may be helpful. For example, the business of medicine, practice management and loss prevention are important concerns for today's medical students. Ethical issues are becoming more and more complex and students must be emotionally prepared before they are faced with such a situation. Family practice has been growing in popularity, although not all medical schools offer it as a field of study. Geriatrics is also increasing in importance as our population grows older.

Despite its problems, I can see rapid improvement in the medical education system. It is becoming more responsive to the changing health care environment, with emphasis on ethical, behavioral, and socioeconomic aspects.

But medical education is not only a construct to be changed for students. Clearly, there is a responsibility for medical students to participate in these changes at all levels. Students must act to take responsibility for their education and provide feedback through appropriate channels on its quality. And, of course, they must work through the system to effect change.

Although all of this comes on top of an already overburdened work week, as medical students, we are obligated to accept the challenge. ◀

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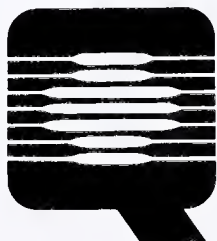
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Today, most commercial professional liability insurers have abandoned the Illinois market. But there's still one company writing malpractice coverage up to \$2 million per incident with a \$4 million aggregate—the Illinois State Medical Inter-Insurance Exchange.

The Exchange is the only malpractice insurer in Illinois that is owned and operated by physicians. As such, we are totally committed to meeting the insurance needs of our policyholders. And we intend to be there as long as they need us.

Despite the recent explosion in medical malpractice litigation, the Exchange remains in good shape financially. Much of our success can be attributed to the willingness of the company's physician directors to make tough decisions—decisions like the switch to a "claims-made" policy form...the setting of adequate premium levels...and the strengthening of standards for renewing coverage and accepting new policyholders.

In the continually changing liability climate, the Exchange's directors will continue to make the sound business decisions necessary to ensure the company's long-term financial stability. But as physicians themselves, they also will be making those decisions from a policyholder's perspective. And that will translate into the best possible insurance coverage available, including...

...aggressive defense of frivolous claims;
...policyholder participation in any decision to settle a claim or suit;

...peer review of an adverse underwriting or claim decision;

...help for policyholders in avoiding the situations that can lead to suits; and

...premium rates that fairly reflect the risks inherent to the physician's own practice.

As a company owned and operated by physicians, the Exchange exists solely for the benefit of its policyholders. Some 9,000 physicians in Illinois are depending upon us. And we don't intend to let them down.

ILLINOIS STATE MEDICAL



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The World's Most Popular K^{*}

Slow-K[®]
potassium chloride
slow-release tablets
8 mEq (600 mg)

It means "dependability" in almost any language

*Based on worldwide sales data on file, CIBA Pharmaceutical Company.
Capsule or tablet slow-release potassium chloride preparations should be reserved for patients who cannot tolerate, refuse to take, or have compliance problems with liquid or effervescent potassium preparations because of reports of intestinal and gastric ulceration and bleeding with slow-release KCl preparations.

Before prescribing, please consult Brief Prescribing Information on next page.

C I B A

The World's Most Popular K

For good reasons

- **It works**—a 12-year record of efficacy¹
- **It's safe**—unsurpassed by any other KCl tablet or capsule^{2*}
- **It's acceptable vs liquids**—greater palatability, fewer GI complaints, lower incidence of nausea²
- **It's comparable to 10 mEq**—in low-dosage supplementation^{3†}
- **It's economical**—less expensive than all other leading KCl slow-release supplements on a per tablet cost to the patient¹



Slow-K[®]
potassium chloride
slow-release tablets 8 mEq (600 mg)

For patients who can't or won't tolerate liquid KCl.

*The most common adverse reactions to potassium salts are gastrointestinal side effects.

†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

C I B A

References: 1. Data on file, CIBA Pharmaceutical Company. 2. Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. 3. Skoutakis VA, Carter CA, Acchiardo SR. Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

Slow-K[®]
potassium chloride USP
Slow-Release Tablets
8 mEq (600 mg)

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

INDICATIONS AND USAGE

BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS

Hyperkalemia (See OVERDOSAGE).

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS

General

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients

Physicians should consider reminding the patient of the following:

To take each dose without crushing, chewing, or sucking the tablets.

To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by a decreased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSAGE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED

Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, but colored, sugar-coated (imprinted Slow-K).

Bottles of 100 NDC 0083-0165-3

Bottles of 1000 NDC 0083-0165-4

Consumer Pack—One Unit

12 Bottles—100 tablets each NDC 0083-0165-6

Accu-Pak[®] Unit Dose (Blister pack)

Box of 100 (Strips of 10) NDC 0083-0165-3

Do not store above 86° F (30° C). Protect from moisture. Protect from light.

Dispense in light, light-resistant container (USP).

Dist. by:

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
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C87-31 (Rev. 8/87)

C I B A

128-3568-4

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(nystatin-triamcinolone
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- ☐ Avoids the #1 irritant in cutaneous reactions¹
- ☐ No methylparaben, propylparaben, or ethylenediamine
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- ☐ Faster, more thorough control of erythema and pruritus than nystatin or triamcinolone alone
- ☐ Unexcelled control of pruritus ani, candidal diaper rash, intertriginous fungal infections associated with diabetes mellitus or chronic maceration

Convenience for compliance

- ☐ b.i.d. regimen
- ☐ Both popular dosage forms—cream and ointment

...and still economical

Please see facing [following] page for brief summary of prescribing information.

Systemic absorption of topical corticosteroids has produced reversible HPA suppression manifestations of Cushing's syndrome, hyperglycemia and glucosuria in some patients. Pediatric patients may demonstrate a greater susceptibility.

Reference: 1. Adams RM, Maiback HI, Clendenning WE, et al: A five-year study of cosmetic reactions. *J Am Acad Dermatol* 1985;13(6):1062-1069.



SAVAGE LABORATORIES
a division of Altana, Inc.
Melville, New York 11747



Mytrex[®] CREAM AND OINTMENT, USP

(nystatin-triamcinolone acetonide)

Brief Summary of Prescribing Information

For Dermatologic Use Only
Not for Ophthalmic Use

INDICATIONS AND USAGE: For the treatment of cutaneous candidiasis; it has been demonstrated that the nystatin-steroid combination provides greater benefit than the nystatin component alone during the first few days of treatment.

CONTRAINDICATIONS: This preparation is contraindicated in those patients with a history of hypersensitivity to any of its components.

PRECAUTIONS: General: Systemic absorption of topical corticosteroids has produced reversible hypothalamic-pituitary-adrenal (HPA) axis suppression, manifestations of Cushing's syndrome, hyperglycemia, and glucosuria in some patients. Conditions which augment systemic absorption include the application of the more potent steroids, use over large surface areas, prolonged use, and the addition of occlusive dressings (see DOSAGE AND ADMINISTRATION). Therefore, patients receiving a large dose of any potent topical steroid applied to a large surface area should be evaluated periodically for evidence of HPA axis suppression by using the urinary free cortisol and ACTH stimulation tests, and for impairment of thermal homeostasis. If HPA axis suppression or elevation of the body temperature occurs, an attempt should be made to withdraw the drug, to reduce the frequency of application, or to substitute a less potent steroid. Recovery of HPA axis function and thermal homeostasis are generally prompt and complete upon discontinuation of the drug. Infrequently, signs and symptoms of steroid withdrawal may occur, requiring supplemental systemic corticosteroids. Children may absorb proportionally larger amounts of topical corticosteroids and thus be more susceptible to systemic toxicity (see PRECAUTIONS, Pediatric Use). If irritation or hypersensitivity develops with the combination nystatin and triamcinolone acetonide, treatment should be discontinued and appropriate therapy instituted.

Information for the Patient: Patients using this medicine should receive the following information and instructions:

1. This medication is to be used as directed by the physician. It is for external use only. Avoid contact with the eyes.
2. Patients should be advised not to use this medication for any disorder other than for which it was prescribed.
3. The treated skin area should not be bandaged or otherwise covered or wrapped as to be occluded (see DOSAGE AND ADMINISTRATION).
4. Patients should report any signs of local adverse reactions.
5. When using this medication in the inguinal area, patients should be advised to apply cream sparingly and to wear loose fitting clothing.
6. Parents of pediatric patients should be advised not to use tight-fitting diapers or plastic pants on a child being treated in the diaper area, as these garments may constitute occlusive dressings.
7. Patients should be advised on preventive measures to avoid reinfection.

Laboratory Tests: If there is a lack of therapeutic response, appropriate microbiological studies (e.g., KOH smears and/or cultures) should be repeated to confirm the diagnosis and rule out other pathogens, before instituting another course of therapy. The following tests may be helpful in evaluating hypothalamic-pituitary-adrenal (HPA) axis suppression due to the corticosteroid: Urinary free cortisol test; ACTH stimulation test.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic or mutagenic potential or possible impairment of fertility in males or females.

Pregnancy Category C: There are no teratogenic studies with combined nystatin and triamcinolone acetonide. Corticosteroids are generally teratogenic in laboratory animals when administered systemically at relatively low dosage levels. The more potent corticosteroids have been shown to be teratogenic after dermal application in laboratory animals. Therefore, any topical corticosteroid preparation should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Topical preparations containing corticosteroids should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

Nursing Mothers: It is not known whether any component of this preparation is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised during use of this preparation by a nursing woman.

Pediatric Use: In clinical studies of a limited number of pediatric patients ranging in age from 2 months through twelve years, Nystatin-Triamcinolone Acetonide Cream cleared or significantly ameliorated the disease state in most patients. *Pediatric patients may demonstrate greater susceptibility to topical corticosteroid-induced hypothalamic-pituitary-adrenal (HPA) axis suppression and Cushing's syndrome than mature patients because of a larger skin surface area to body weight ratio.* HPA axis suppression, Cushing's syndrome, and intracranial hypertension have been reported in children receiving topical corticosteroids. Manifestations of adrenal suppression in children include linear growth retardation, delayed weight gain, low plasma cortisol levels, and absence of response to ACTH stimulation. Manifestations of intracranial hypertension include bulging fontanelles, headaches and bilateral papilledema. Administration of topical corticosteroids to children should be limited to the least amount compatible with an effective therapeutic regimen. Chronic corticosteroid therapy may interfere with the growth and development of children.

ADVERSE REACTIONS: A single case (approximately one percent of patients studied) of acneiform eruption occurred with the use of combined nystatin and triamcinolone acetonide in clinical studies.

Nystatin is virtually nontoxic and nonsensitizing and is well tolerated by all age groups, even during prolonged use. Rarely, irritation may occur.

The following local adverse reactions are reported infrequently with topical corticosteroids. These reactions are listed in an approximate decreasing order of occurrence: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae and miliaria.

DOSAGE AND ADMINISTRATION: Cream: Apply MYTREX[®] (Nystatin-Triamcinolone Acetonide) Cream, USP to the affected area twice daily in the morning and the evening by gently and thoroughly massaging the preparation into the skin. Ointment: A thin film of MYTREX[®] is usually applied to the affected area twice daily in the morning and evening. MYTREX[®] should be discontinued if symptoms persist after 25 days of therapy. (See PRECAUTIONS, Laboratory Tests). MYTREX[®] should not be used with occlusive dressings.

Caution: Federal law prohibits dispensing without prescription.



R 4/87

"I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state.

The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 1440 W. Washington Blvd., Chicago 60607. Telephone (312) 243-2000.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

In addition, the American Cancer Society provides Fresh Start clinic training anywhere in Illinois for hospitals and industries. Educational materials, pamphlets, posters, films and training can also be obtained at no charge. For information, contact your local ACS office, or the Illinois Division, Inc., at 37 South Wabash Ave., Chicago 60603; (312) 372-0471.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

June 6	Weiss Memorial Hospital	Chicago
June 7	Rush North Shore Medical Center	Skokie
June 14	Carle Clinic	Urbana
June 15	St. Therese Medical Center	Waukegan
To Be Announced	Ambutal	Crystal Lake
	Copley Memorial Hospital	Aurora
	Delnor Community Hospital	St. Charles
	Dreyer Clinic	Aurora
	Field Medical Group	Chicago
	Highland Park Hospital	Highland Park
	Hinsdale Hospital	Hinsdale
	Memorial Hospital for McHenry Cty.	Woodstock
	Mendota Community Hospital	Mendota
	Northern Illinois Med. Ctr.	McHenry
	Ravenswood Health Care Ctr.	Chicago
	Resurrection Hospital	Chicago
	Sherman Hospital	Elgin
	South Suburban Hospital	Hazel Crest
	West Town Public Health Clinic	Chicago

Poor Resident Participation

Who's to Blame?

*By TIMOTHY KUZEL, M.D., IMMEDIATE PAST CHAIRMAN, ISMS
RESIDENT PHYSICIANS SECTION*

Recruitment of students and residents at the national, state and county levels has recently been a high priority. But despite this effort, it seems that little has changed with regard to resident physician participation.

It is important to contrast membership statistics in the national, state and county societies from active participation at those levels. In Illinois there are over 4,600 residents, 852 of whom are members of the AMA and ISMS. In Cook County there are approximately 3,900 residents and 714 members of the Chicago Medical Society.

Members vs. Active Members

I have been actively involved in organized medicine throughout residency and fellowship in Illinois. Before that, I was an AMA member in medical school. Over that time, it's become clear that the number of colleagues who are truly active members is a contrast to these impressive membership statistics.

Two years ago, the leadership of the Resident Physicians Section in Illinois held a reception with several speakers to address resident issues and encourage membership and participation. How many nonmembers did we attract? Very few, despite a county-wide announcement regarding the event and phone calls to chief residents to encourage attendance.

Most recently we held our annual ISMS Resident Physicians Section meeting. This meeting is called to elect our officers and executive committee for the coming year. Every resident member in the state was notified thirty days in advance of the meeting and of its import. Since we speak for residents state-wide, and control the organization's budget, we expected a large crowd. Did we draw one? Hardly. We rarely attract more than a dozen members to our meetings and this was no exception.

Time As An Investment

What reasons do residents give

for their apathy? I have heard many. Most frequently, residents tell me that their time is precious and they must guard it carefully. I don't think young physicians can make this claim more than any other young professionals. Four to five hours per month seems a small amount of time to dedicate to a large organization which purports to speak for your profession in setting policy. This is especially true when important issues, such as legislative attacks on graduate medical education, or health care financing, are front page news on a daily basis. Influence, or rather the lack of influence, is another frequently mentioned reason for their lack of interest. Many residents feel that the members of the national and state societies are not sympathetic to our interests. There may be some truth in that. Issues important to residents are often bitterly opposed on the floors of the assemblies, sometimes for no clear reason. On the other side of the coin, organized medicine has provided a forum to present resident issues

and concerns, many of which have gone on to shape ISMS and AMA policies and activities. Win or lose, we are heard!



Role Models Relevance to Academics

Finally, and perhaps most importantly, is the influence of our role models in teaching institutions. Many academic physicians feel that organized medicine is important to physicians in private practice, but does not influence their own practice. Regretfully, they tend to impart this feeling to the medical students and resident physicians they encounter. The last few years of drastic change have shown that academic physicians are no longer sheltered from changes in the medical practice climate, but the damage to resident participation persists.

It would be easy to stop at this point: place blame but offer no solutions. But, as a member of the ISMS-RPS I feel I must try. A simple way to encourage resident participation would be for the parent organizations to consider resident concerns more openly and view our input with less condescension. If their interests are respected, residents will be more likely to become involved. Increasing membership among medical school faculty would also help. A change in their attitudes could only benefit the recruitment process for the Medical Student Section, the Resident Physicians Section, the Young Physicians Section, and ultimately their sponsoring state and national societies. And, finally, residents themselves need to wake up and realize that organized medicine is trying to protect the interests of all physicians, young and old. Without a broad-based, active membership, physicians will be left without a strong voice to address issues of concern.



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The following is a brief summary.

WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or

without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The

following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak[™] unit-of-use bottles of 100.

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Widowed . . . Five Years Later

By MRS. JESSIE FULCHER, R.N. (HERSHEL),
Co-CHAIRMAN, ISMSA WIDOW COMMITTEE

Five years ago, life was filled with the typical challenges of a physician's spouse: carpools, P.T.A., volunteer projects, and preparing dinner, then holding it for varying hours. It all changed when my physician husband died unexpectedly at age 51.

Physicians are trained to anticipate complications, to know the probable outcome of disease or illness with or without treatment. This same concern must be carried over in the physician's private life. The doctor and spouse must consider the needs of the family in the event of his or her death.

The physician and spouse should allocate time each year to evaluate financial status, set goals, discuss and record comments about wills, safe deposit boxes, insurance, partnerships, children, funerals and organ donation. Although talking about these things is distasteful, this simple plan of communication is the most caring gift a spouse can leave the family. I received this gift and it helped me to focus on living rather than on death. It was a bridge in my transition from "care taker" to "care giver."

Personal friends and members of

the Sangamon County Medical Auxiliary were very supportive during my "care taker" stage and I will forever be indebted for their caring support in helping me through difficult times. The second way in which the auxiliary was helpful to me has to do with the purpose and goals of the organization. While a member, board member and president of the Sangamon County Medical Society Auxiliary, I became more fully aware of one of the objectives of our auxiliary . . . to identify health needs in Springfield and central Illinois. As a registered nurse, I was responsive to these needs.

I learned a good deal about the health care needs of our aging population while working on auxiliary projects. As medical knowledge and technology continue to grow, our life expectancies grow in tandem. In 1988, 10% of Americans who die will be over 85. In 10 years, the proportion will be 50%, one-third of whom will suffer from some form of dementia. As spouses, we can expect that physicians will continue to work long and hard hours. As community leaders, we should anticipate the needs of aging people

who can still lead active lives.

Recognizing these facts helped me to realize that there was a match between what the community needed and what I could provide. I decided to start my own business for that purpose, and to work with auxiliary to fulfill the need through community leadership. The widowed auxiliary has much information to share with fellow members and her experiences can be a valuable resource. She has learned to deal with the courts, lawyers, grieving families, investment firms, partners, and real estate people who are ready to sell the house before the funeral is complete. The auxiliary is a ready-made support group for those who are facing a transition because of the death of a spouse.

The physician demonstrates his compassion by how he cares for his patients. He demonstrates his compassion and love for his family by how he prepares for them in the event of an unexpected death. Make preparations now so your family members have choices for their futures. ◀

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BOT ABSTRACTS

(continued from page 362)

Medical Practice Act being proposed by other groups, and directed that specific positions be adopted in response.

- Adopted the Requests for Changes in Membership Status.
- Ratified submission of Resolution 22 for the 1988 House of Delegates which establishes the title of Executive Vice President replacing the title Executive Administrator.
- Authorized the Chairman of the Board to express ISMS concerns on the proposed "Healthy Kids" rule if the situation requires.
- Approved an outline of the role and function of the Ad Hoc Committee to the Third Party Payment Processes Committee.
- Approved sending a letter to the Director of the Department of Professional Regulation, offering the Committee's resources in educating the staff and Board members about issues of physician impairment.
- Agreed to: (1) Adopt "Physician Assistance Committee" and "Physician Assistance Program" as the new names of the ISMS committee and program for impaired and troubled physicians; and (2) Submit a resolution to the 1988 House of Delegates changing the name of the committee and the program in all ISMS documents and publications.
- Agreed to send a letter to the Illinois High School Association recommending that shin guards be made mandatory for high school soccer players.
- Approved an amended policy statement titled "Laboratories" for retention in the Policy Manual.
- Approved deletion of the Board position statement titled "Blood Banking" from the ISMS Official Actions manual.
- Approved changes in Public Service Award criteria.
- Approved proposed revisions to the ISMS Goals and Objectives.
- Agreed to support preparations for making the 150th Anniversary of the ISMS a celebration by the membership and an event to enhance the ISMS' image among the public.
- Approved funding from the "undesignated surplus" account, the HMSS campaign for the AMA HMSS' Governing Council's Member-At-Large position, in the amount of \$1,500.
- Elected Dr. Harold L. Jensen, Harvey, as Chairman.
- Nominated Drs. Phillip Boren, Alfred Clementi, Ulrich Danckers, Robert Hamilton, Jerry Ingalls and Alfred J. Kiessel, for the ISMIS Board of Directors.
- Appointed Alexander R. Lerner as proxy for the shareholder, Illinois State Medical Society, at the annual meeting of ISMIS, May 4, 1988, to cast the proxy vote for Directors of ISMIS.

NOMINATIONS AND APPOINTMENTS

The Board made the following nominations and appointments:

- Nominated: (1) Dr. Donald F. Pochly, Chicago, to serve on the ACCME Committee on Review and Recognition; and (2) Drs. George Gallant, Buffalo Grove; John Ruthman, Peoria; Ron Lee, Chicago; C. Otto Metzmaker, Springfield; Dennis Uehara, Rockford and Darrell Rust, Bloomington, to serve as IDPH trauma center surveyors.
- Named Dr. Edward Fesco as an observer to the Cook County Department of Public Health Sex Education Task Force.
- Re-appointed Drs. Alan Roman, Flossmoor, as delegate and Michael Davidson, Oak Park, as alternate delegate, to the 1988 Annual Meeting of the AMA's Young Physician Section Assembly.

OTHER MATTERS

- The Board adopted a motion expressing gratitude and respect for the work performed by past chairmen of the Board. By this a commemorative plaque, honoring ISMS Board of Trustees chairmen who have served since May, 1962, will be established at the ISMS office.
- Officers and Trustees completing terms of office were presented plaques in appreciation of their service.
- Certificates of Appreciation were presented to ISMS staff members. Larry Boress for 15 years of service; Holly Boone, Peter Che, Eliese Diercks, Mary Elligan, Shelly Fleming, Laura Hutchinson, Maeola Mack, Dorothy Rupe, Kenneth Ryan, Laurel Schwartz and Maria Stephens for 10 years.

INFORMATIONAL ITEMS

The Board filed December 31, 1987, Audited Financial Statements and Schedules for Illinois State Medical Society, Illinois State Medical Benevolent Fund, Inc., The Educational and Scientific Foundation of Illinois State Medical Society; March 31, 1988, IMPAC Collection Data; March 31, 1988, Dues Payment Report.

Dr. Jensen, in order to constitute the Executive Committee, appointed Dr. Alfred Clementi chairman of the Finance Committee and Dr. Ronald Welch chairman of the Policy Committee.

Informational reports were presented by Committee on CME Accreditation, ISMIS, ISMIE, Resident Physicians Section, Medical Student Section, IMPAC, Trustees, Speaker of the House, AMA Delegation Chairman and AMA Trustee Dr. John J. Ring.

NEXT MEETING

The next Board of Trustees meeting was set for June 11, 1988, at ISMS Headquarters. ◀

A NEW H₂ Antagonist

AXID[®] 300mg

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Effective once-nightly
duodenal ulcer therapy available in a
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AXID[®] nizatidine capsules

Brief Summary. Consult the package insert for prescribing information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H₂-receptor antagonists.

Precautions: General—1 Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2 Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3 Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy with nizatidine.

Drug Interactions—No interactions have been observed between Axid and theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system, therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement

compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established. **Use in Elderly Patients—Ulcer** healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported, it was not possible to

Axid[®] (nizatidine, Lilly)

determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of androgenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecostasia occurred.

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H₂-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD₅₀ values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively. PV 2091 AMP [041288]

Axid[®] (nizatidine, Lilly)



Eli Lilly and Company
Indianapolis, Indiana
46285

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Transderm-Nitro[®]

nitroglycerin 2.5 mg/24 hr, 5 mg/24 hr, 10 mg/24 hr, 15 mg/24 hr



Helps angina patients get more out of life

Significantly reduces both the frequency of anginal attacks and the need for sublingual nitroglycerin. Preferred by patients over 7 to 1 for convenience compared to their previous long-acting oral nitrate; only 12% had no preference (n = 4,300)²

All transdermal nitroglycerin products are being marketed pending final evaluation of effectiveness by the FDA. Please consult Brief Summary of Prescribing Information on the following page.

BRIEF SUMMARY (FOR FULL PRESCRIBING
INFORMATION, SEE PACKAGE INSERT)

INDICATIONS AND USAGE

This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS

Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS

In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring. In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class. Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS

Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued. Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS

Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.

Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur.

DOSAGE AND ADMINISTRATION

Therapy should be initiated with application of one Transderm-Nitro 5 mg/24 hr system to the desired area of skin. Many patients prefer the chest, if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.

The usual dosage is one Transderm-Nitro 5 mg/24 hr system. Some patients, however, may require the Transderm-Nitro 10 mg/24 hr system. If a single Transderm-Nitro 5 mg/24 hr system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 mg/24 hr systems or one Transderm-Nitro 10 mg/24 hr system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 mg/24 hr system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone. The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs. Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS

A patient leaflet is supplied with the systems.

Printed in U.S.A. 629-5557-A C87-23 (Rev. 7/87)

C I B A

Dist. by:
CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

1. Martinez C: Comparison of the prophylactic anti-anginal effect of two doses of Nitroderm TTS in out-patients with stable angina pectoris. *Curr Ther Res* 1984;36:483-489.

2. Brady EM, Gold OG, Rosenberg H: Transdermal nitroglycerin antianginal comparative trial involving oral nitrates: The Transderm-Nitro A.C.T.I.O.N. Study. Presented at 2nd Cardiovascular Pharmacotherapy International Symposium, San Francisco, October 1987.

Illinois Society of Medical Assistants

President's Message

By ROBIN BLUESTEIN, CMA-C

A new year has begun for the Illinois Society of Medical Assistants. This gives an opportunity to reaffirm and expand upon our organizational goals. The Illinois Society is more than 30 years old, and the medical assisting profession has existed for an even longer period of time. Unfortunately, many members of the medical community and the general public are unfamiliar with our profession.

A medical assistant "is a professional multi-skilled person dedicated to assisting in all aspects of medical practice under the supervision of a physician." The practitioner assists with patient care management, executes administrative and clinical procedures, and often performs managerial and supervisory functions. Competence in the field also requires that a medical assistant communicate effectively, adhere to ethical and legal standards of professional practice, recognize and respond to emergencies and demonstrate professionalism.

If the physician reading this definition shares it with several of his/her colleagues, the medical assisting profession can begin to become more recognized.

Two of my main focuses this year are the importance of a positive attitude and good communication among members on all three levels of our organization. A positive attitude may help our members appre-

ciate their profession and our organization, leading to more active involvement in issues relating to medical assisting. As in all organizations, there can be a problem with communication. I believe I have an executive board whose members can work well together, communicate well with the entire membership and keep the lines of communication open.

Another goal this year is to increase membership. Although our membership declined several years ago, it has shown an increase this past year. I believe, as membership increases, the main purposes and objectives of our organization will follow: excellent educational programs; recognition by our peers and the general community; and providing the best service possible as professionals of the medical community.

Information regarding the Illinois Society and/or medical assisting can be obtained from Robin Bluestein, CMA-C, president, Illinois Society, 10471 Dearlove Road #1B, Glenview 60025; Lucille Perce, CMA-C, co-chairman, public relations committee, 22 W. 384 Teakwood Dr., Glen Ellyn 60137; or Ehlma Garcia Mendez, CMA, EMT-A, co-chairman, public relations committee, 5015 Briartree #311, Burbank 60459. We welcome all inquiries. ◀



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- head and orbits: axial and coronal capability
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- reconstruction capability
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- dynamic flow procedures
- special temporal bone evaluation
- future capabilities

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Siemens Digital B-mode and Stand Alone Phased Array Real Time Scanning

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- obstetrical
- pelvic
- aortic
- special thyroid

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- renal
- peripheral vascular
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Diplomate American Board of Radiology

MARK GREENBERG, M.D.

Diplomate American Board of Radiology

1988 Annual Meeting House of Delegates

The ISMS House of Delegates met at the Westin O'Hare Hotel in Rosemont, April 22-24, 1988, and took the following actions. The official minutes of the House are on file at the headquarters office of the Illinois State Medical Society.

UNFINISHED BUSINESS

36 (A-87) Not Adopted
(BOT Report A)—*Medical Studies Act*

Introduced by William E. Kobler, M.D., for the Winnebago County Medical Society

Defeated this resolution which called upon ISMS to introduce and support legislation to include medical corporations and medical clinics under the provisions of the Medical Studies Act.

Substitute 49 (A-87) Adopted
(BOT Report B)—*Anti-Physician Letters*

Introduced by Roger N. Klam, M.D., for the Jackson County Medical Society

Directed that the Society introduce a resolution to the AMA urging it to seek legislative and/or regulatory change to the ERISA statute. The purpose of this would be to address the problem of self-insured employers inducing patients to avoid paying physician bills by offering to pay the legal expenses of and indemnify patients who refuse to

pay more than the amount allowed by the payor.

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

13 (A-88) Not Adopted
Inclusion of Opinion Disclaimers on JAMA Essays

Introduced by Joseph R. O'Donnell, M.D., for the DuPage County Medical Society

Defeated this resolution, which called upon the Society to: (1) Recommend to the AMA that in the future essays not be printed in the journal without appropriate disclaimers and restatement of relevant AMA policies and principles of medical ethics; and (2) That the Illinois delegation to the AMA submit a resolution at the next AMA Annual Meeting directing the AMA to include appropriate disclaimers and restatements of relevant AMA policies and principles of medical

ethics with essays published in JAMA.

21 (A-88) Referred to Board for Study

Medical Staff Bylaws for Outpatient Surgi-Centers

Introduced by Robert M. Vanecko, M.D., for the Cook County Delegation

Referred to the Board of Trustees for study a proposal that the Society adopt the policy that all licensed free-standing Surgi-Centers (Ambulatory Surgical Treatment Centers, ASTC) have medical staff bylaws and that the due process section of these bylaws be consistent with the due process guidelines as provided by the IDPH Hospital Licensing Act; and that the ISMS seek legislative reform in the appropriate licensing act.

22 (A-88) Adopted
Amend Chapter VII, Section 3 of Bylaws, Title of Executive Administrator

Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that ISMS Bylaws, Chapter VII, Section 3, be amended to read: "Section 3. Executive Vice President. The Board of Trustees shall employ an executive vice president whose duties shall be determined by the Board. He shall be responsible to the chairman of the

Board. The Board shall review at each of its meetings the interim activities of the executive vice president. . . ." Further directed that the title Executive Administrator be changed to Executive Vice President in any other portions of the bylaws, *e.g.*: Chapter VII, Section 5B.

Substitute 31 (A-88) Adopted

Telephone Information

Introduced by Chester C. Danehower, M.D., for the Peoria Medical Society

Directed that: (1) The Society policy on Confidentiality and Utilization Review be amended to include the statement that "a request for patient information should be accompanied by appropriate authorization and appropriate releases"; and (2) That it is an ISMS policy that third party payors should not delay reimbursement for their failure to provide appropriate releases from patients.



ISMS President Edward J. Fesco, M.D., presents memorial plaque to Mrs. Patricia Goslin, commemorating Allan L. Goslin, M.D., who died suddenly last May, only three weeks after assuming office as ISMS president. "Al's tenure was tragically short, but characterized nonetheless by his boundless energy and enthusiasm," Dr. Fesco said. "We thank you and your children for sharing your husband and father with us. On behalf of our members, I assure you that his many, many contributions will be remembered for a long time to come."

Substitute 43 (A-88) Adopted

Justification of Restraints in Long-Term Care Facilities

Introduced by Jodie Rai, for the Medical Student Section

Directed that the policy of the Society be that the use of restraints in long-term care facilities be permitted only when medically indicated and approved by the patient's attending physician.

59 (A-88) Adopted

Change in the Name of the Committee for the Impaired Physician

Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that the Society change the name of its committee and program to assist impaired and troubled physicians to the "Physician Assistance Committee" and "Physician Assistance Program"; and that this change be reflected in all ISMS documents and publications.

Reports

Filed for information the following reports:

Committee on Constitution and Bylaws, Policy Committee.

REFERENCE COMMITTEE A

1 (A-88) Not Adopted

Medical Malpractice Juries

Introduced by Edwin S. Sinaiko, M.D., Delegate

Defeated this resolution, which called upon the Society to cause legislation to be introduced so that in cases of medical malpractice, doctors or other scientists knowledgeable in the matter brought to trial, would be mandated to serve on the juries otherwise peopled by the laity.

2 (A-88) Adopted

Dues

Introduced by Harold L. Jensen, M.D., Secretary-Treasurer, for the Board of Trustees

Directed that the Society: (1) Adopt a \$78 increase in annual dues to the Illinois State Medical Society in 1988, effective the 1989 dues year, making total dues of \$351 for a full dues paying member; and (2) Make no further increase of dues through 1991.

10 (A-88) Not Adopted

Monitor Malpractice Insurance in Illinois

Introduced by Samuel J. Schimel, M.D., Delegate

Defeated this resolution, which called upon the Society to monitor the premium increases of all insurance companies writing malpractice insurance in Illinois and notify the members in advance of any increase in insurance premiums.

33 (A-88) Not Adopted

Medical Malpractice Expert Opinion

Introduced by Edwin S. Sinaiko, M.D., Delegate

Defeated this resolution proposing that it be ISMS policy that in a medical malpractice suit, a medical expert who gives an opinion on a plaintiff's behalf be mandated to fully disclose any fee or other compensation received for providing such expert opinion; and that this policy include the position that the specialist who provides an opinion for the affidavit indicating that a case is indeed one of malpractice, be specific as to why

such is the case, rather than merely stating that it is an "opinion" without specific reasons.

Directed that the Society continue to review its position regarding joint and several liability.

Defeated this resolution, which would have required that all future financial reports be expanded to include specific cost data of various operations, including personally identifiable salary matters.

41 (A-88) Adopted As Amended
Joint and Several Liabilities Doctrine
Introduced by Raymond W. Nemecek,
M.D., Delegate

48 (A-88) Not Adopted
ISMS Financial Reports
Introduced by Albert W. Ray, Jr.,
M.D., for the Will-Grundy County
Medical Society

Tell the Truth and Run

Edward J. Fesco, M.D., liked to quote an old Czechoslovakian phrase, "Tell the truth and run," to describe his President's Tour. His parting address was marked by characteristic candor.

"I spoke to hundreds of physicians throughout the state this year," he told the House. "They told me about pressures related to malpractice and litigation. And they spoke of the inept, often insulting intrusions of federal and state alphabetized agencies."

"Our members realize that we must join together more effectively to represent our concerns and our patients' concerns," he said. "Don't become disgruntled over something trivial like a business decision. Remember Ben Franklin's warning to his compatriots: 'Yes, we must indeed, all hang together, or most assuredly we shall hang separately.'"

Fesco called upon members to communicate with their patients. "I talked with service organizations, chambers of commerce, reporters, media interviewers, call-in programs, students, old and young people—patients all," he said. "People are hungry for information from you—their doctor. Patients are looking for your human side. You're entitled to an opinion. Speak to them. Ask them what is bothering them. Tell them what is bothering you. Be an artist as well as a scientist."

Much of Dr. Fesco's President's Tour concerned AIDS



Edward J. Fesco, M.D. (L) accepts past president's medallion after administering the oath of office to his successor, ISMS President Harry A. Springer, M.D. (R).

education. "People look to us for guidance in their community, and counseling when it reaches their friends and acquaintances," he said. "Remember, we are the 'experts.' With a million people carrying the virus who will sicken and die at great expense in the next decade, we must be careful and accurate about what we know. And even more accurate about what we don't know about this disease and what to do about it. Don't panic when that first AIDS

patient comes in or you start to run out of rubber gloves. You have to be the educator and counselor."

"AIDS will give a new boost to sex education," he predicted. "You have an opportunity now to talk about these things. We can thank the Surgeon General for desensitizing the population. Go to your high schools. Join the school board. Be a source of factual information."

"And remember, these are the good old days." ◀

50 (A-88) Adopted As Amended
Communication with Senior Citizens
Introduced by Theodore M. Kanellakes, M.D., for the Will-Grundy County Medical Society

Directed that the Society seek to strengthen the communications link with the Illinois Chapter of the American Association of Retired Persons and other interested senior citizens' organizations in Illinois.

Reports

Filed for information the following reports:

President, President-Elect, First Vice-President, Secretary-Treasurer, 1987 Dues by County, Chairman of the Board of Trustees, Trustees, Executive Administrator, Illinois State Medical Insurance Services, Planning and Priorities Committee, Publications Committee, Illinois Delegation to the American Medical Association, Illinois State Medical Society Auxiliary, Education and Scientific Foundation, Hospital Medical Staff Section, Resident Physicians Section, Medical Student Section.

REFERENCE COMMITTEE B

6 (A-88) Adopted
ISMS Policy Titled, "Minimum Standards for Health Insurance Policies"
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that the following policy statement be deleted from the ISMS Policy Manual: "Minimum Standards for Health Insurance Programs."

8 (A-88) Adopted As Editorially Amended
ISMS Policy Titled, "Inadequate HMO Psychiatric Benefits"
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that the Society delete the following ISMS policy statement from the ISMS Policy Manual: "Inadequate HMO Psychiatric Benefits."

Substitute 11 (A-88) Adopted in Lieu of 11, 12, 58 (A-88)
Medicare Denials

Introduced by John Taraska, M.D., for the Peoria Medical Society

"Medically Unnecessary" Letters

Introduced by Samuel J. Schimel, M.D., Delegate

General Accounting Office Investigation of the Actions of the Health Care Financing Administration in Implementing Medicare's "Medical Necessity Screens"

Introduced by Wayne H. Leimbach, M.D., for the Kane County Medical Society

Directed that the Society: (1) Support repeal of those portions of the Medicare law which allow suspension or rejection of claims on the basis of medical necessity before physician peer review of the claims has occurred; (2) And its members contact the Illinois Congressional Delegation in support of such repeal; (3) Bring a similar resolution to the AMA; and (4) Pursue with the AMA the possibility of a GAO investigation into HCFA's actions in implementing this initiative.

Substitute 14 (A-88) Adopted
Informing Medicare Beneficiaries of Potential Denials

Introduced by Robert Fitzgerald, M.D., for the DuPage County Society

Directed that the Society develop

an informational instrument to be used by physicians as guidelines to document that the patient has been informed of potential Medicare denial for a given service and agreed to pay for the service.

16 (A-88) Adopted
Repeal of MAAC Provisions

Introduced by Joseph O'Donnell, M.D., for the DuPage County Medical Society

Directed that the Society: (1) Request the AMA to seek repeal of the MAAC provision of the 1986 Omnibus Budget Reconciliation Act; and (2) That the Illinois delegation to the AMA introduce a resolution calling for repeal of the MAAC provision at the next AMA Annual Meeting.

Substitute 20 (A-88) Adopted
Utilization Parameters for Nursing Home Visits

Introduced by Joseph O'Donnell, M.D., for the DuPage County Medical Society

Directed that the Society ask the AMA to seek immediate changes in the HCFA utilization parameters to allow payment for treating severely ill patients in the nursing home when used as an alternative to an acute hospitalization.



ISMS past presidents gather for their annual gourmet dinner. Seated (L-R) are Morgan M. Meyer, M.D., Immediate Past President Jere E. Freidheim, M.D., and Robert C. Hamilton, M.D. Standing (L-R) are Herschel Browns, M.D., Willard C. Scrivner, M.D., Joseph H. Skom, M.D., Fred Z. White, M.D., George T. Wilkins, Jr., M.D., Frank J. Jirka, Jr., M.D., P. John Seward, M.D., Fredric D. Lake, M.D., J. M. Ingalls, M.D., Robert P. Johnson, M.D. and C.J. Jannings, III, M.D.

32 (A-88) Referred to Board for Study

Eliminate Discrimination Against Patients in Health Insurance Coverage
Introduced by Silvana Menendez, M.D., Delegate

Referred to the Board of Trustees for study a proposal that ISMS policy be modified to support the inclusion of required nondiscriminatory psychiatric benefits in health insurance policies written in Illinois; and that ISMS actively support efforts to improve the delivery of health care in Illinois, by modification of the laws and promotion of non-discrimination in benefits afforded Illinois citizens who are in need of psychiatric care.

Substitute 34 (A-88) Adopted

Allocation of Medicare Administrative Expenses

Introduced by Robert M. Vanecko, M.D., Chairman, Cook County Delegation

Directed that the Society publicize, on a continuing basis, specific financial information on the portion of Medicare dollars which are allocated for the health care of senior citizens but spent on administrative expenses.



Delegate Jack Whitney, immediate past chairman of the ISMS Medical Student Section, participates in House debate.

38 (A-88) Adopted

Medicare's Ambulance Service Regulations

Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed that the Society urge

the AMA to support changes in Medicare regulations governing ambulance service coverage guidelines which would expand the term "appropriate facility" to allow payment for transport to facilities other than the closest, based upon the physician's judgment; and that the ISMS delegation to the AMA introduce a resolution to this effect.

Substitute 42 (A-88) Adopted As Amended

Medicare Review

Introduced by W. G. Thielemann, M.D., for the McLean County Medical Society

Directed that the Society: (1) Work to ensure that PRO standards and criteria are developed and applied equitably; (2) Act to initiate any measures deemed appropriate including the involvement of HCFA, the AMA, and the Congressional Delegation to ensure that these PRO standards, criteria and procedures are implemented in a proper manner; (3) Support the concept that only qualified, practicing physicians be designated as reviewers of physicians in the same specialty being reviewed; and (4) Bring a similar resolution to the AMA.

51 (A-88) Referred to Board for Study

Coalition for Medicare

Introduced by Stanley Rousonelos, M.D., for the Will-Grundy County Medical Society

Referred to the Board of Trustees for study a proposal that: (1) The physicians of Illinois, through the ISMS, seek to establish and maintain a coalition of organized medicine, Medicare recipients and other interested parties; (2) That coalition use its collective political power to strengthen the Medicare system; and (3) The ISMS, through its delegation to the AMA's House of Delegates, introduce a resolution calling for the establishment of a nationwide coalition of a similar nature.



Members of the ISMS Fifty Year Club.

Substitute 55 (A-88) Adopted
Illinois Department of Public Aid (IDPA) Reimbursement
Introduced by Kishore Thampy, M.D.,
Delegate

Directed that: (1) ISMS adopt as a priority goal the attainment of adequate funding of the Medicaid program; and (2) Funding levels be sought which allow a meaningful reduction in the payment cycle.

Reports

Filed for information the following reports:

Committee on Health Planning,
Committee on Third Party Payment Processes, Council on Economics

REFERENCE COMMITTEE C

3 (A-88) Adopted
ISMS Policy titled "Disaster Teams"
Introduced by Alfred J. Kiessel, M.D.,
for the Board of Trustees

Directed that the Society delete the ISMS policy titled "Disaster Teams" from the ISMS Policy Manual.

4 (A-88) Not Adopted
ISMS Policy titled, "Hospital Procedures with Mental and Physical Illness"

Introduced by Alfred J. Kiessel, M.D.,
for the Board of Trustees

Defeated this resolution, which called upon the Society to delete the ISMS policy titled, "Hospital Procedures with Mental and Physical Illness" from the ISMS Policy Manual.

5 (A-88) Not Adopted
ISMS Policy titled "Involuntary Certification"

Introduced by Alfred J. Kiessel, M.D.,
for the Board of Trustees

Defeated this resolution, which called upon the Society to delete the policy titled, "Involuntary Certification" from the ISMS Policy Manual.



William Hotchkiss, M.D., American Medical Association president, addresses the House of Delegates on AMA involvement in national issues, such as Medicare's "medical necessity" letters and evaluation of relative value studies.

7 (A-88) Adopted As Amended
ISMS Policy titled "Workers Compensation"

Introduced by Alfred J. Kiessel, M.D.,
for the Board of Trustees

Amended the ISMS Policy on "Workers Compensation" to read as follows: "ISMS opposes the need for repeat radiology examinations of the same bodily part or parts performed in the course of evaluating an individual in a worker's compensation case, unless a significant change in the patient's condition has taken place or is suspected. The referring physician should furnish all pertinent x-rays and records to the examining physi-

cian within an appropriate period."

9 (A-88) Adopted As Amended
Physician Manpower and Its Projected Future Excess

Introduced by Edward S. Warren, M.D., Delegate for the Vermilion County Medical Society

Directed that during the next year, the Society address the issue of physician maldistribution in the State of Illinois.

23 (A-88) Adopted
Hospital Closures or Mergers—Guidelines for Medical Staff

Introduced by Dennis M. Brown, M.D.,
for the Hospital Medical Staff Section

Directed that the Society develop guidelines for pertinent items to be considered by a physician or medical staff when a hospital closes or merges.

26 (A-88) Adopted As Amended
Postgraduate Education for Physicians in Foreign Countries

Introduced by Dennis M. Brown, M.D.,
for the Hospital Medical Staff Section

Directed that the Society investigate ways for foreign physicians to be able to obtain postgraduate continuing education and training in the United States and Illinois, and that ISMS encourage foreign physicians to participate in United States postgraduate education so that this would aid their countries, their fellow physicians and their patients.

27 (A-88) Adopted
Storage of Physician Credentials and Performance Files

Introduced by Dennis M. Brown, M.D.,
for the Hospital Medical Staff Section

Directed that the Society pursue with diligence the matter of the disposition of the staff physician credentials and performance files upon an Illinois hospital's closing, and that the necessary (ISMS) policy, legal, and legislative issues be addressed by ISMS.

Substitute 36 (A-88) Adopted In

Speaking Out for Quality

In his inaugural address, ISMS President Harry A. Springer, M.D., promised to seek greater public understanding of health care issues pertaining to the adolescent and aging patient populations. He stressed the continued importance of medical malpractice tort reform, and highlighted a new communications initiative from the Society.

"The aim of our continuing campaign to protect adolescent health," Dr. Springer told the House, "is to reduce infant mortality and teen parenting, and prevent sexually transmitted disease—especially AIDS. Infant mortality ties directly into an important, and as yet unmet, state obligation: allocating enough money for indigent health care through the public aid program. Without obstetricians, pediatricians, internists and family doctors to care for indigent mothers and their babies, infant mortality will persist. And without public aid reimbursement even approaching the cost of medical malpractice insurance and other overhead costs, more and more doctors will drop out."

Turning to health care for the aging population, Dr. Springer said, "In recent years, we've all felt the crunch. Medicare is tightening its belt, squeezing more and more from patients, physicians and hospitals, and threatening to go even further."

"Those threats are real," he continued. "On the horizon is the long-anticipated release of a resource-based 'relative value scale' for physician services. This Harvard study compares what different physicians in different specialties do, in terms of time and complexity. Points, or relative values, are assigned to each of our skills and procedures. These points will be tied to com-



Newly inaugurated ISMS President Harry A. Springer, M.D., holds daughter Margo. His spouse, Mavis, and son, David, look on.

pensation. Most likely, this will be a vehicle to further shrink and perhaps reallocate the Medicare pie."

"Rampant cost-cutting is fast producing a two-tiered medical system," Dr. Springer warned. "We are the patient's advocates, and we know more than government bureaucrats and Harvard academics about front-line medical care for our elderly patients. We must continue to speak out and fight for quality."

Turning to yet another of his four priorities for the year, Dr. Springer reiterated the importance of tort reform. "This is a very important election year," he said. "A presidential race always sparks a lot of public interest. Let's capitalize on that interest by becoming active in our communities. Work for state and local candidates you approve and help 'relieve' those you don't. We will win caps only through winning elections."

Finally, the newly-inaugurated president turned to a new communications initiative scheduled for launch in January 1989. "As a result of your feedback in surveys and focus groups throughout the state," he said, "the Society is revamping its publications. *Illinois Medicine* will be a new

socioeconomic newspaper which you'll receive twice monthly. It will be timely, interesting and sometimes controversial reading, geared to spark your interest and inform you about key issues. Please share it with your patients, legislators and news media representatives to help them understand the challenges facing medicine in Illinois today."

"As many of you know, I'm a plastic surgeon," he concluded. "I deal with fixing scars, improving a person's self image, minimizing the effects of trauma. These kinds of problems are reminiscent of the forces buffeting medicine today."

"We have scars from the battles fought on medical malpractice, Medicare and other fronts. They have made us wiser. We've seen cost-cutting trauma grip the profession. It has renewed our commitment to quality. We've watched our self-image and our public image diminish. And that has challenged our complacency in community outreach and brought us back to the basics of our Hippocratic Oath. It is these positive counterpoints to each of the challenges facing medicine today that I will try to communicate within and without our profession."

Speaker Gives National Perspective

The keynote speaker, syndicated columnist George F. Will, brought a good-humored approach to national politics when he addressed the House on Friday morning.

"The deficit is only a numerical expression of our cultural tendency to consume rather than invest," syndicated columnist George F. Will told the House of Delegates. "Ours is not a society that reinforces delayed gratification."

"The federal government does not have the revenue base sufficient to pay the bills we are determined to incur," he said, warning that a tax increase would be likely in the near future. "The American people talk a ferocious campaign against big government," he said. "But one in six is a federal employee and one in seven is a beneficiary of transfer payments."

Mr. Will cited the aging of America, coupled with rapid technological advancement, as fundamental forces in national health care policymaking. "Increasingly," he said, "the budget is a mechanism for transferring wealth in the U.S. from the young to the old. The 70% of the health care budget we now spend on Social Security and Medicare will only increase in years to



come."

Citing the difficult choices posed by economics and technology, Will encouraged physicians to seek out their legislators and communicate on the issues. "We have to let our political leaders know that it is safe to talk sense to a reasonable electorate," he said.

states that the quality of medical training is an appropriate concern in the recruiting and credentialing of physicians. However, it is inappropriate to discriminate against any physician because of national origin or geographic location of medical education.

Substitute 46 (A-88) Adopted
Recognition of Childhood Sexual Abuse as a Factor in Adolescent Health Issues

Introduced by Jodie Rai, for the Medical Student Section

Directed that the Society: (1) Include childhood sexual abuse in efforts to confront adolescent health issues; and (2) Through its AMA Illinois Delegation, forward a related resolution to the AMA House of Delegates at its 1988 Annual Meeting, asking the AMA to study the prevalence of childhood sexual abuse and its contributions to teenage pregnancy and sexual abuse.

47 (A-88) Adopted As Amended
Aedes Albopictus Infestation in Urban Areas of the United States
Introduced by Jodie Rai, for the Medical Student Section

Directed that the Society encourage and advise the Illinois Department of Public Health in: (1) The study of the actual prevalence of *A. albopictus* in Illinois and the potential morbidity and mortality as a result of its presence; (2) The development of health policy, sanitation standards, and medical intervention in response to the diseases carried by this mosquito species; and (3) Public awareness programs, if necessary, informing the community at large of the problem of *A. albopictus* in Illinois.

53 (A-88) Adopted As Amended
Aid to the University of Illinois College of Medicine & Hospital
Introduced by Judith Peters, M.D., for the Resident Physicians Section and Jodie Rai, for the Medical Student Section

Directed that the Society encourage the State of Illinois to maintain its commitment to quality medical education and health care for all the people of Illinois.

57 (A-88) Not Adopted
Tuberculosis in Illinois
Introduced by Donald R. Graham, M.D., for the Sangamon County Medical Society

Defeated this resolution, which called upon the Society to endeavor to educate its members

Lieu Of 28, 36, 52, 54 (A-88) As Amended

Medical Licensure Under the Medical Practice Act of 1987

Introduced by Vedantham Sprinivasan, M.D., for the DuPage County Medical Society

Directed that the Society: (1) Explore all possibilities in creating a mechanism for initial licensure of qualified applicants who graduated from medical school prior to 1985; and (2) Reaffirm its 1985 policy titled "Discrimination Against Physicians" which

about the rising incidence of tuberculosis in the State of Illinois, and that it communicate, especially with physicians who provide care for children, the importance of early and vigorous treatment of tuberculosis in those patients, and that it co-sponsor with the Illinois Department of Public Health biannual regional seminars about the diagnosis and treatment of tuberculosis in Illinois.

60 (A-88) Adopted
ISMS Policy titled, "Laboratories"
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed the Society to update and expand its policy titled "Laboratories," as follows: It is the policy of ISMS that hospital and private independent clinical laboratories that are currently certified by and meet the standards of the College of American Pathologists' Inspection and Accreditation Program should be considered to have deemed status by the Illinois Department of Public Health and not be required to

undergo unnecessary, duplicative annual licensure inspections.

Reports

Filed for information the following reports:

Task Force on Financial Aid to Medical Students, Medical Student Loan Fund, Drugs and Therapeutics Committee, Council on Medical Services, Council on Mental Health and Addiction, Council on Education and Manpower, Committee on CME Accreditation, Committee for the Impaired Physician, Illinois Department of Public Health, Illinois Department of Rehabilitation Services, Illinois Department of Mental Health and Developmental Disabilities, Illinois Department of Alcoholism and Substance Abuse, Illinois Department on Aging.

REFERENCE COMMITTEE D

15 (A-88) Adopted As Amended
Protection of Retirement Assets
Introduced by Patricia A. Merwick, M.D., for the DuPage County Medical Society

Directed that the Society support legislation to protect retirement plans from seizure to satisfy a judgment.

Substitute 17 (A-88) Adopted In Lieu of 17, 18, 19(A-88)
Smoking Ban in Public Buildings and Restaurants
Introduced by Robert E. Fitzgerald, M.D., for the DuPage County Medical Society

Directed that the Society support legislation banning smoking in all Illinois public buildings, restaurants, hospitals, public health facilities and public transportation vehicles, except when designated areas are provided.

24 (A-88) Referred to Board for Study
Mandatory Informed Consent of HIV Testing



IMPAC Chairman George T. Wilkins, Jr., M.D., urged delegates to seek opportunities to persuade their colleagues of the value of political involvement. He also reported that ten Illinois hospital medical staffs had contributed to IMPAC in 1987-88, and added his support for their commitment. Hospital medical staffs cited for 1987 contributions were those affiliated with St. Anne's, Ingalls Memorial, South Suburban, Edward, and Resurrection Hospitals. Those contributing in 1988 were on staff of Evanston, Edward, Elmhurst Memorial and Good Samaritan Hospitals, and the Carle Clinic.

Introduced by Dennis M. Brown, M.D., for the Hospital Medical Staff Section

Referred to the Board of Trustees for study a proposal that the Society be opposed to the January 1, 1988, Illinois Public Law on Mandatory Informed Consent for HIV testing; and actively work with the state legislature to repeal this law during the spring 1988 session of the Illinois General Assembly.

25 (A-88) Adopted As Amended
Mandatory Pre-Marital HIV Testing
Introduced by Dennis M. Brown, M.D., for the Hospital Medical Staff Section

Directed that the Society actively work with state legislators to repeal this law as soon as possible.



(L-R) Anthony L. Barbato, M.D., Alfred J. Kiessel, M.D., chairman, ISMS Board of Trustees, and Mrs. Evelyn Perlmutter, ISMS Auxiliary AMA-ERF chairman, on presentation of ISMS/ISMSA contribution to Illinois medical schools. Dr. Barbato accepted the checks, totalling \$119,000 in unrestricted grants and \$21,000 for medical student financial assistance, as a representative of the Illinois Council of Medical School Deans.

29 (A-88) Adopted As Amended
Premarital Examination Certificate Language

Introduced by Albino T. Bismonte, M.D., Delegate

Directed that the Society cause to be introduced legislation to change the language of the premarital examination certificate so that the physician can attest only to the known facts.

30 (A-88) Adopted As Amended
Certification for Emergency Admissions

Introduced by Lorin D. Whittaker, M.D., for the Peoria Medical Society

Directed that the Society seek the enactment of legislation or regulations which would prohibit third parties' avoiding their financial responsibilities to patients who require emergency hospitalization.

Substitute 35 (A-88) Adopted As Amended

Good Samaritan Act

Introduced by Robert M. Vanecko, M.D., Chairman, Cook County Delegation

Directed that the Society review the Illinois Good Samaritan Act with the aim of expanding its scope.

37 (A-88) Adopted As Amended
AIDS as an Occupational Hazard for Health Care Workers

Introduced by Raymond A. Dieter, Jr., M.D., for the DuPage County Medical Society

Directed that the Society cause to be introduced and support legislation which would assure classification of AIDS as an occu-

Public Service Awards Commend Community Leaders

The 1988 ISMS Public Service Awards singled out The Care Center of Springfield as nonphysician recipient and Luke Burchard, M.D., Mattoon, as physician recipient, for community service.

"This year, I have spent much of my time and travels urging our media, our parents, our teachers, and our young people to take heed of the dangers of early adolescent sexual activity," said ISMS President Edward Fesco, M.D., in presenting the nonphysician award to Carolyn Bodewes of The Care Center of Springfield. "Because of our Society's message to Illinoisans this year, I am especially proud to honor our 1988 nonphysician public service award winner. This organization has been in the forefront for many years, helping prospective mothers in Springfield, Illinois, toward better health and quality of life."

"The Care Center of Springfield exists and thrives in troubled times for obstetrical care," Dr. Fesco said. "And that is because they work hand-in-glove



Carolyn Bodewes, representing The Care Center of Springfield and Luke Burchard, M.D., 1988 recipients of ISMS Public Service Awards.

with Springfield's medical community to find care for those who need it, in full understanding of

the problems buffeting medicine today."

Dr. Fesco related his trip to

pational hazard disease to be covered through Workers' Compensation for all health care providers who contract AIDS in the course of rendering professional care.

39 (A-88) Adopted

Cessation of Federal Tobacco Subsidy
Introduced by Forrest H. Riordan, III, M.D., for the Winnebago County Medical Society

Directed that the Society through its AMA Delegation introduce resolutions that: (1) Call for federal legislation to cease all subsidies from the federal government to farmers growing tobacco; and (2) Ask that the federal government, for the next three years after termi-

nation of subsidies, spend an equal amount of money to help needy tobacco farmers to switch into production of other agriculture products.

40 (A-88) Not Adopted

Tobacco Product Package Labeling
Introduced by Forrest H. Riordan, III, M.D., for the Winnebago County Medical Society

Defeated this resolution which asked that the ISMS-AMA Delegation introduce a resolution calling for federal legislation requiring the tobacco product manufacturers to print an easily identifiable skull and crossbones emblem on the back and sides of each package of cigarettes, chewing tobacco, cigars and snuff.

44 (A-88) Not Adopted

Speed Limits and Trauma
Introduced by Jodie Rai, for the Medical Student Section

Defeated this resolution which called upon the Society to ask the AMA to: (1) Review the impact changes in the speed limits have had on traumatic deaths and injury; and (2) Encourage its component societies to review the impact of changes in speed limits on the traumatic death and injuries and report their findings to the state and local governments and regulatory agencies which may enact or designate changes increasing speed limits above 55 mph.

the state capital to testify before a federal congressional committee on the relationship between infant mortality problems and low Medicaid reimbursement for obstetrical care. He said that he had expected to be the sole spokesman for physician concerns, but that those testifying from The Care Center, "spoke more eloquently than I of the profession's problems and their impact upon the health and well-being of Springfield mothers and their babies."

The Care Center provides crisis intervention, counseling and education to persons in distress within their community. They place particular emphasis on problem and teen pregnancies. Patient education on the importance of prenatal care and referral to a local obstetrician are part of the service provided to new mothers in Springfield.

In accepting the award for The Care Center of Springfield, Project Director Carolyn Bodewes said that their work would not be possible without the cooperation of the local med-

ical community. Concerned physicians had made up one-third of the founding board of directors ten years before, she said.

Physician Award to Mattoon, MD

Family physician Luke Burchard, M.D., was selected as the 1988 Physician Public Service Award winner. Burchard, who last year chaired the Illinois Interagency Council on Smoking and Disease and is president of his local American Cancer Society chapter, has long been identified with community health education.

"For many years, we've individually and collectively battled cigarette smoking and its high social, health and economic costs," said Dr. Fesco in presenting the award. "That's where our Physician Public Service Award winner steps into the picture. He's found time not only to lead the charge against smoking, but to handle other community projects as well."

Dr. Fesco told the House that Burchard had been credited with

helping build the coalition which drafted the Illinois Clean Indoor Air Act, then pending before the Illinois legislature. And he had helped to plan youth rallies on drug and tobacco use drawing more than 3,000 Rockford students and another 1500 in Springfield.

"This physician does more than educate his own patients about the dangers of smoking, drugs and alcohol," Dr. Fesco said. "He seeks out forums to get his message across. For instance, last year he organized, judged and helped fund a poster contest for his community's local school system. Almost 1,000 entries were displayed at the local mall. Here's a physician who truly works to keep his patients and his community healthy."

"I'm just a country doctor trying to make a living," protested Dr. Burchard in accepting the award. "We've been trying for a long time to find ways to teach patients about lifestyle and preventive medicine issues. It's a sign of the times that what I do is really not unique." ◀

ISMIE Network Meeting Answers Policyholder Questions

Wondering what the new insurance year will hold for Exchange policyholders? Have a question about defense strategies in malpractice cases or coverage for paramedical employees?

Illinois State Medical Inter-Insurance Exchange policyholders heard about new rates and programs, and had a chance to query Exchange leaders at the ISMIE Network Meeting during the ISMS Annual Meeting. The one-hour Saturday forum was sponsored by the Policyholder Services Committee, which oversees the ISMIE Network.

About 60 policyholders attended the session, where they received copies of the annual report of the Exchange, as well as the 1988-89 rate schedule. The meeting was open to Network reps, Exchange policyholders and anyone interested in learning more about the Exchange.

Robert C. Hamilton, M.D., chairman of the Illinois State Medical Insurance Services (ISMIS) Board of Directors, opened the meeting with a presentation on ways ISMIS is improving claims, underwriting and legal team operations to benefit policyholders.

Fred Z. White, M.D., chairman of the ISMIE Board of Governors, outlined the new rates and program changes for 1988-89. The meeting was moderated

by Boyd E. McCracken, M.D., chairman of the Policyholder Services Committee.



ISMIE Network Chairman Boyd McCracken, M.D.



ISMIS Board of Directors Chairman Robert C. Hamilton, M.D.

ISMIS recently completed an internal audit of the claims and underwriting divisions, Dr. Hamilton reported, resulting in developments that will improve service to policyholders.

ISMIS has prepared a manual to be followed by defense firms in defending ISMIE insureds and developed objective criteria for evaluating the performance of defense firms.

Company Stable

Dr. Fred White described the healthy position of the Exchange today. A major influence has been the decline in claims filed since the tort reforms of 1985: there have been 30% to 38% fewer claims since the changes took effect. Later in the meeting, Dr. White was able to inform the House of tentative Department of Insurance approval for redemption of outstanding Guaranty Fund Certificates.

Dr. White also announced that physicians entering their third year of claims-made coverage would see a premium increase of 8.2% over the second-year rates for the coming policy year. First and second year rates had actually decreased.

Also, he reported that the Exchange was offering a new group/clinic policy for groups of 25 or more physicians.



U.S. Congressman Henry J. Hyde (R-Sixth District) told physicians attending the annual Public Affairs Breakfast that their political involvement was key to intelligent health care policy-making. "The sensitive relationship between a doctor and a patient cannot be put into a formula," he said in reference to government mandates regarding health care. "Humanity and judgment are essential components."

Society: (1) Oppose the January 1, 1988, Public Law on Mandatory Informed Consent for HIV testing; and (2) Actively work with the State Legislature to repeal this law during the Spring 1988 session of the Illinois General Assembly.

Reports

Filed for information the following reports:

Governmental Affairs Council, Medical Legal Council, Illinois Society of Medical Assistants, Council on Public Relations and Membership Services and Illinois Department of Professional Regulation.

MEMORIAL RESOLUTIONS

The House also adopted memorial resolutions in memory of Drs. Allan L. Goslin, Lee N. Hamm and Harold A. Sofield

and expressed its profound loss and condolences to their families.

ELECT OFFICERS, TRUSTEES, AMA DELEGATES

Dr. Harry A. Springer, Evanston, was installed as ISMS President, succeeding Dr. Edward J. Fesco, LaSalle.

Election of Officers

At the concluding session of the House, 1988-89 officers were elected unanimously. They are: *Drs. Eugene P. Johnson, Casey, president-elect; Pedro A. Poma, Melrose Park, first vice-president; Donald K. Rokosch, Danville, second vice-president; Boyd E. McCracken, Greenville, secretary-treasurer; Robert M. Reardon, Bloomington, speaker of the House, and Joan E. Cummings, Hines, vice speaker of the House.*

45 (A-88) Adopted As Amended Medical Student Development and Implementation of AIDS Education Projects
Introduced by Jodie Rai, for the Medical Student Section

Directed that the Society urge its members to lend their support and assistance to medical students in the development and implementation of community appropriate AIDS education projects targeted toward adolescents.

49 (A-88) Referred to Board for Study
Mandatory Informed Consent for HIV Testing
Introduced by Van L. Hicks, M.D., for the Will-Grundy County Medical Society

Referred to the Board of Trustees for study a proposal that the



Seated, (L-R) Mrs. Raymond E. Hoffmann, ISMS Auxiliary president-elect and Mrs. Wesley Betsill, newly-installed ISMSA president. Standing behind them are the members of the newly-named ISMS Auxiliary Board of Directors. The ISMSA Annual Meeting, held in conjunction with the ISMS House of Delegates meeting, featured an educational panel on adolescent health, and speakers from the American Medical Association Auxiliary and the ISMS Physician Assistance Committee. The Auxiliary House of Delegates approved resolutions encouraging community education programs on organ donation and drug abuse prevention.

Election of Trustees

Elected trustees were: *Drs. Ulrich F. Danckers*, River Forest, *Harold L. Jensen*, Harvey, and *William J. Marshall*, Olympia Fields, Third District; *Lorris M. Bowers*, Peoria, Fourth District; *Alfred J. Kiessel*, Decatur, Seventh District.

Judicial Panel

Dr. Donald E. Morehead, Ottawa, was elected to serve a five year term on the ISMS Judicial Panel.

Illinois AMA Delegates

The House of Delegates elected AMA delegates and alternates to serve January 1, 1989 through December 31, 1990. Elected delegates were: *Drs. James H. Andersen*, *Joan E. Cummings*, *Gail D. Herman*, *Henrietta Herbolsheimer*, *Lawrence L. Hirsch*, *Joseph B. Perez*, *Pedro A. Poma*, *P. John Seward*, *Robert M. Vanecko*, *Fred Z. White* and *George T. Wilkins*. Elected alternate delegates were



(L-R) *Howard Chodash*, *Bill McDade* and *JoAnne Micale* confer during a break in the ISMS Medical Student Section Annual Meeting, held in conjunction with the ISMS House of Delegates. The students elected a new governing council, to be chaired by *K. Gregory Lucchesi* of Northwestern Medical School. Also elected were *Simone Tizes*, Chicago Medical School, vice chairman, *Prerna Mona Khanna*, UI Rockford, secretary/editor, *Mary Wade Martin*, UI Rockford, delegate to ISMS and *Robert Klem*, SIU Springfield, alternate delegate.

Drs. Juanito S. Bartolome, Jr., *H. Constance Bonbrest*, *Audley F. Connor, Jr.*, *Chester C. Danehower*, *Edward J. Fesco*, *Manuel Guerrero*, *Roger N. Klam*, *Eugene B. Loftin* and *William J. Marshall* and *Mr. Scott Bernstein*. *Dr. Alfred J. Kiessel* was elected delegate to serve immediately and until December 31, 1989. *Drs. Clair M. Callan* and *Edward J. Fesco* were elected alternate delegates to complete unexpired terms until December 31, 1989.

Rules and Order of Business

Appointed to the 1989 House of Delegates Rules and Order of Business Committee were *Drs. Alan M. Roman*, Flossmoor, chairman; *Julius C. Araujo*, Chicago; *Albino T. Bismonte*, Gurnee; *Eugene B. Loftin*, Elgin; and *Joseph B. Perez*, Rockford.

1989 Dues

The secretary-treasurer announced that the per capita dues for 1989 would be \$351.

President's Night Dinner Dance



Henrietta Herbolsheimer, M.D., hosted an evening gala honoring ISMS President Edward J. Fesco, M.D. Physicians and their guests enjoyed Dr. Herbolsheimer's gracious comments, as well as the music of Franz Benteler and The Royal Strings. And in a departure from tradition, Dr. Fesco was the subject of a slide show highlighting his President's Tour, which was narrated by Fred Z. White, M.D.



Clockwise from top right: Dr. Fesco with the evening's chairperson, Henrietta Herbolsheimer, M.D.; Mrs. Edward Fesco; Dr. and Mrs. Wayne Kassel; Dr. and Mrs. Fred Z. White; Dr. and Mrs. Robert Reardon; Dr. and Mrs. Alfred J. Kiessel; Dr. Fesco and four of his five daughters; Mr. and Mrs. Alexander R. Lerner; Dr. and Mrs. Harold Jensen.



Issues and Advocates



Debate on the floor of the ISMS House of Delegates and in reference committee hearings is the heart of the annual meeting. Here, elected leaders flesh out their ideas, and their differences, in a classic model of representative democracy.

This year, sixty resolutions were before the 300 delegates. Topics ranged from psychiatric benefits in health insurance policies to Medicare "medical necessity" denials. The House voted unanimously to increase Society dues. They firmly supported proposals to discourage use of tobacco and considered problems with the Medicaid program. Adolescent health care concerns were prominent, as were those related to AIDS. The top media stories proved to be their firm stand in opposition to premarital HIV screening tests, and the extended debate—ending in referral for study—of the state law requiring written informed consent prior to HIV screening tests.



Clockwise from top left: Robert M. Reardon, M.D., Harlan J. Failor, M.D., Michael R. Treister, M.D., Charles A. Beck, M.D., James A. Bull, M.D., Melvin J. Freedman, M.D., Harold Goodman, M.D., Orlan W. Pflasterer, M.D.



Clockwise from top left: Albert W. Ray, Jr., M.D., Harry A. Springer, M.D., Jodie K. Rai, MSS Delegate, James McGee, M.D., Edward S. Warren, M.D., Albino T. Bismonte, M.D., Joan E. Cummings, M.D. Center: Arvind K. Goyal, M.D.



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Chairman (<i>Ex-Officio</i>)	
ISMIS Board of Directors	Robert C. Hamilton, M.D., 711 W. North Ave., Chicago 60610
Chairman (<i>Ex-Officio</i>)	

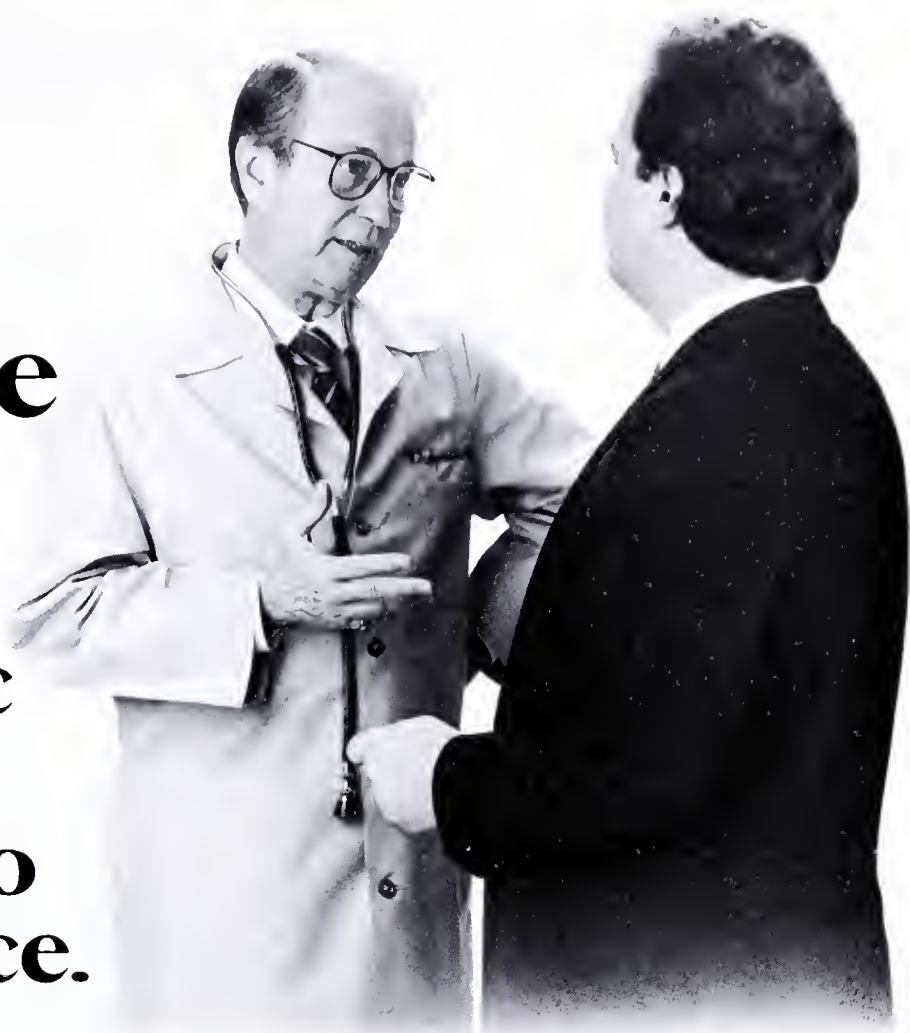
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Compiled for Illinois physicians by the Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 782-1654.

July

Allergy

Clinical Allergy for the Practicing Physician

For: Physicians. Seminar, July 21-23, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** \$175. **Reg. Limit:** 150. **Credit:** Category 1: 15 hours; AAFP Prescribed: 15 hours; and ADA: 15 hours. **Contact:** Loretta Giacometto. **Phone:** (800) 325-9862.

Emergency Medicine

Specialty Review in Emergency Medicine

For: Emergency, family, and internal medicine practitioners. Lecture, July 25-30, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, IL 60612. **Fee:** \$690. **Reg. Limit:** None. **Credit:** Category 1: 53 hours; AAFP Prescribed: Applied for; and ACEP Category 1: Applied for. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Medicine

Specialty Review in Internal Medicine

For: Internists and medical subspecialists. Lecture, July 31-Aug. 7, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, IL 60612. **Fee:** \$765. **Reg. Limit:** None. **Credit:** Category 1: 65 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Pediatrics

Specialty Review in Pediatrics

For: Pediatricians. Lecture, July 17-23, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, IL 60612. **Fee:** \$765. **Reg. Limit:** None. **Credit:** Category 1: 64 hours; AAFP Prescribed: TBA; and AAP(PREP): 64 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

August

Obstetrics/Gynecology

Gynecologic Surgical Techniques

For: Obstetricians and Gynecologists. Lecture, July 25-27, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, IL 60612. **Fee:** \$515. **Reg. Limit:** 75. **Credit:** Category 1: 21 hours; ACOG Formal Learning: 20 cognates. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or

sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

Surgery

Specialty Review in Surgical Critical Care

For: Surgeons and Critical Care Specialists. Lecture, Aug. 15-19, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, IL 60612. **Fee:** \$645. **Reg. Limit:** None. **Credit:** Category 1: 35 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Specialty Review in General Surgery, Part I

For: General and specializing surgeons. Lecture, Aug. 22-Sept. 2, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, IL 60612. **Fee:** \$880. **Reg. Limit:** None. **Credit:** Category 1: 94 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Surgery, Ophthalmology, Dermatology

Laser Use and Safety Issues

For: Physicians and other health professionals. Conference, August 25-26, Madison, WI. **Sponsor:** University of Wisconsin-Madison, Continuing Medical Education, 2715 Marshall Court, Madison, WI 53705. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1: 10 hours; AOA Category 2-D: 10 hours; University of Wisconsin CEH: 10 hours. **Contact:** Cathy Means, Program Coordinator. **Phone:** (608) 263-6637.

September

Anesthesiology

The Use and Interpretation of Monitoring and New Technologies

For: Anesthesiologists. Symposium, Sept. 9-11, Chicago, IL. **Sponsor:** University of Chicago School of Medicine, Center for CME, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** \$275. **Reg. Limit:** 250. **Credit:** Category 1: 15.5 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Cardiology

Advances in Echocardiology

For: Cardiologists. Symposium, Sept. 8-9, Chicago, IL. **Sponsor:** University of Chicago School of Medicine, Center for CME, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** \$100. **Reg. Limit:** 200. **Credit:** Category 1: 11 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Dermatology

Specialty Review in Dermatology

For: Dermatologists. Lecture, Sept. 19-24, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, IL 60612. **Fee:** \$645. **Reg. Limit:** 90. **Credit:** Category 1: 39 hours; AAD Category 1: 39 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Internal Medicine

Specialty Review in Pulmonary Disease

For: Internists and pulmonologists. Lecture, Sept. 26-30, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, IL 60612. **Fee:** \$645. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Specialty Review in Infectious Disease

For: Internists and infectious disease specialists. Lecture, Sept. 26-30, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, IL 60612. **Fee:** \$645. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Specialty Review in Hematology

For: Hematologists, oncologists, and internists. Lecture, Sept. 26-30, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, IL 60612. **Fee:** \$645. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Ophthalmology

Cornea, Cataract and Lasers '88

For: Ophthalmologists. Symposium, Sept. 17, Chicago, IL. **Sponsor:** University of Chicago School of Medicine, Center for CME, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** TBA. **Reg. Limit:** 200. **Credit:** Category 1: TBA. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Ophthalmology, Neurology, Radiology

Clinical Neuro-Ophthalmology Symposium

For: Ophthalmologists, neurologists, and radiologists. Symposium, Sept. 9-10, The Wisconsin Center, Madison, WI. **Sponsor:** UW-Madison, CME and the Depts. of Ophthalmology and Neurology, School of Medicine, UW-Madison, 2715 Marshall Court, Madison, WI 53705. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1: 7 hours; UW CEH's: 7 hours. **Contact:** Cathy Means. **Phone:** (608) 263-6637. ◀

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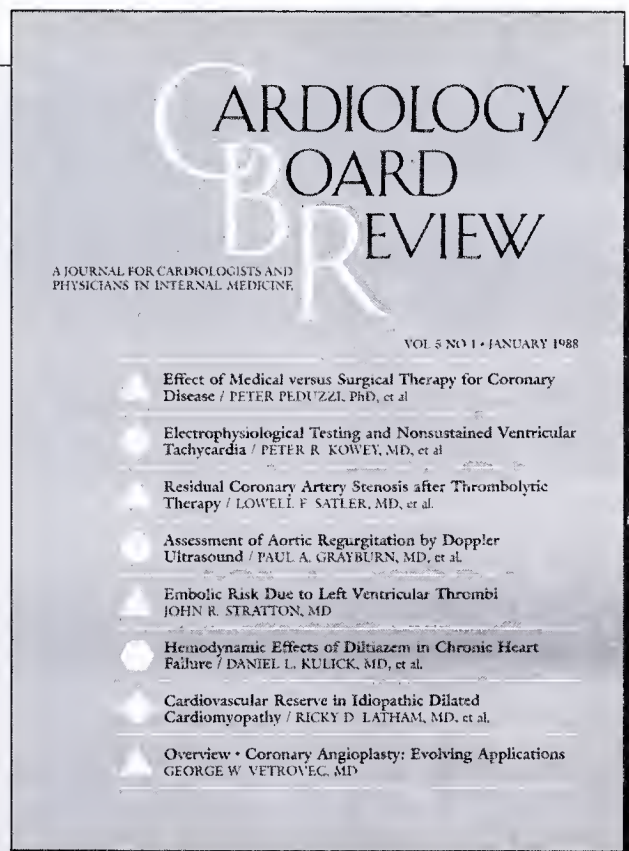


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*Journals reviewed include: *Circulation*, *American Heart Journal*, *Journal of the American College of Cardiology*, *British Heart Journal*, *Chest*, *The American Journal of Cardiology*, *The New England Journal of Medicine*, *Annals of Internal Medicine*, *American Journal of Medicine*, and *The Journal of the American Medical Association*.

PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

ALTON:

Population in St. Louis metro area is over 2 million. Located 25 miles from downtown St. Louis. Four community hospitals available for staff privileges. Opportunities for internal medicine, cardiology, neurology, gastroenterology, pediatrics, oncology, and anesthesiology. Fully equipped offices available. Scheduled hours, free rent, staff salary support, marketing assistance, partnership shares are available and attractive income support arrangements. Contact Jan C. Vest, Administrator, Doctors Clinic, Alton, Illinois (618) 474-8000 or 800-325-3571. (6)

CRYSTAL LAKE:

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assured of a lucrative practice, plus a real challenge. Contact: John E. Monnahan, Administrator, Clay County Hospital, 700 North Mill, Flora, IL 62839; (618) 662-2131, ext. 228. (7)

FLORA:

Small, progressive hospital in southern Illinois seeks family practitioner. Beautiful small town, scenic area, yet only an hour's drive from major metropolitan areas. Financial assistance and office space available. Contact: John E. Monnahan, Administrator, Clay County Hospital, 700 North Mill, Flora, IL 62839; (618) 662-2131 ext. 228. (9)

MACOMB:

Chief of staff. Western Illinois University is accepting applications for medical chief of staff at its Health Center. This is a 12 month position in a multi-faceted outpatient clinic serving 11,000 students. Starting date July 1, 1988. Salary competitive and commensurate with experience. Excellent fringe benefits, malpractice paid. A letter of application along with a curriculum vitae and three references should be forwarded to: Mr. Earl Bracey, Chairman, Search Committee for Medical Chief of Staff, 315 Sherman Hall, W.I.U., Macomb, IL 61455. Ethnic minorities, women and handicapped persons are encouraged to apply. (6)

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Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

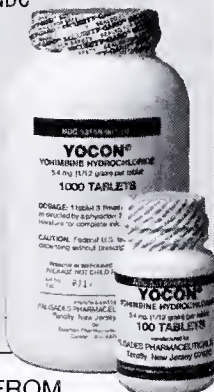
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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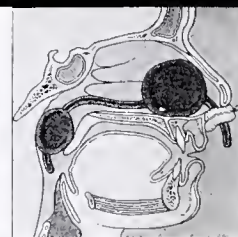
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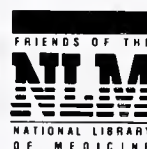
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